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ABSTRACT

Research confirms anecdotal impressions of the following causes of high turnover among both home health and nursing home aides: low wages; inadequate benefits; excessive workloads; poor training, supervision, and working conditions; and job-related stress. Public policy initiatives can dramatically alleviate or exacerbate the crisis among long-term care workers. Such policies include cost control efforts of the past 5 years and recently enacted legislation to promote quality in nursing home and home health care. Most research done on long-term care workers has focused on home health aides. Future research should focus on the problems encountered by nursing home aides. A market area study of the nursing home work force and a study of states' compliance with new aide training requirements would help fill this gap. Future research should focus on similarities between these two categories of workers, with a view to streamlining planning for future needs and funding. Demonstration projects testing the success of various intervention methods in alleviating the long-term care worker shortage should be tested. Public policy should encourage successful passage of state-level legislation to improve conditions for long-term care workers. (Appendixes, amounting to over one-half of the report, include recommendations to Congress on access to health care and long-term care, a transcript of a bill to amend title XIX of the Social Security Act pertaining to the pay of nursing personnel, 7 newspaper and journal articles, and a 15-item bibliography.) (YLB)

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OLDER WOMEN'S LEAGUE

CARING FOR CAREGIVERS:

ADDRESSING THE EMPLOYMENT NEEDS OF LONG TERM CARE WORKERS

A Report by the Older Women's League

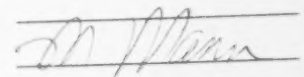
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RESEARCH AGENDA ON PROJECTS TO IMPROVE THE STATUS OF LONG TERM CARE WORKERS

I. The Need for Additional Research

A. The Problems Faced by Long Term Care Workers

Providing adequate, affordable health care is perhaps the number one domestic problem facing American families today. As people in our nation continue both to age and to live longer, health care for the elderly and disabled has moved to the forefront of the public policy arena. A 1987 national poll by R.L. Associates showed that nearly half of all Americans have faced the long term care issue in their own families, and another 20 percent expect to face the issue within five years. The strategies for providing long term care are complex. How do we insure adequate, quality care for millions of aged and infirm individuals? How do we contain costs for this care to make it accessible to the average person? How do we attract enough paid caregivers to fill unmet and growing needs?

At the crux of these issues -- particularly those surrounding the quality of care -- is the long-term care worker. This worker has been all but invisible in the planning and design of healthcare industry and national public policy. It is this worker who makes beds, gives baths, sees that medicine is taken and otherwise cares for the physical and emotional needs of elderly and disabled individuals. Without those caregivers who work as home health aides, the majority of elderly and infirm individuals would be unable to remain in their own homes as part of the community. This worker is on the "front lines" of caregiving.

Relatively little is known about long-term care workers, but what we do know, gives us cause for concern. Conservative figures estimate that they number about 1.5 million.¹ They are overwhelmingly women (93%) and include a disproportionate number of minority and foreign-born women.² They are usually middle-aged, poorly trained, and often

¹ Alice Quinlan, "Chronic Care Workers: Crisis among Paid Caregivers of the Elderly," (Older Women's League, 1988), p. 3.

² "Employed Persons by Detailed Occupation, Sex, and Race," Annual Averages, Employment and Earnings, vols. 25 - 35 (January 1978 - 1988).

undereducated.³

Long term care workers are employed by more than 25,000 nursing homes⁴ and about 12,000 home health agencies.⁵ They are known by scores of job titles: in nursing homes, where they are usually called "nursing aides," it is estimated they provide up to 90% of patient care⁶; those who provide caregiving services in patients' homes are most often called "home health aides". A majority of these caregivers work in for-profit institutions and agencies.⁷ They earn low wages -- wages for home care workers average \$4.25 an hour, but many work at the current minimum wage. Nurses aides do only a little better, averaging \$4.50 an hour⁸. Most are not covered by health insurance, and very few have access to pension coverage. Even if health insurance is offered, most cannot afford the premiums and co-payments on their low pay.⁹

Given the low wages and benefits, it is not surprising that long term care workers change jobs or leave the field entirely. Among nursing home workers, nurses aides have the

³ National Center for Health Care Statistics, Genevieve Strahan, "Nursing Home Characteristics: Preliminary Data from the 1985 National Nursing Home Survey." Advance Data from Vital and Health Statistics no. 131, March 27, 1987 (Public Health Service, Hyattsville, Md.)

⁴ National Center for Health Statistics, Al Sinocco, "Nursing and Related Care Homes as reported from the 1986 Inventory of Long Term Care Places," Advance Data from Vital and Health Statistics no. 147, January 22, 1988 (Public Health Service, Hyattsville, Md.)

⁵ U.S. Senate Committee on Aging, "Home Care at the Crossroads," Special Committee on Aging (April, 1988, p. 20; and Foundation for Hospice and Homecare, "Basic Home Care Statistics: the Industry 1988." (1988). p. 6.

⁶ National Center for Health Statistics, "Full Time Equivalent Employees in Nursing and Related Homes, 1985," Advance Data, no. 131, Table 5, see note 3.

⁷ Bureau of Labor Statistics, "National Industry - Occupational Matrix, 1986 -20," p. 524.

⁸ Bureau of Labor Statistics, "Industry Wage Survey: Nursing and Personal Care Facilities (1987), Tables 2-45 and 49.

⁹ National Center for Health Statistics, Al Sirrocco, "Employees in Nursing Homes in the United States: 1977 National Nursing Home Survey," Vital and Health Statistics Series 14, no. 25, February 1981, pp. 7-8 and Table 6.

highest turnover rates, ranging from 70 to 100 percent a year.¹⁰ It is not uncommon for half the aides in a facility to leave their jobs within the first six months. The turnover rate for home care workers is 60 percent a year, on average, with 80 to 90 percent leaving within two years.¹¹ Bales (1975) identified the following reasons for turnover among longterm care workers: a) insufficient orientation; b) lack of knowledge about how to do the job; and c) supervisor's lack of management skills.

In the years ahead, we will face a serious shortage of workers willing to take these low paying, physically and emotionally demanding jobs. Long term care workers are already in extremely demanding jobs. Long term care workers are already in extremely short supply today in some areas, most notably in northeastern states (such as Massachusetts) and in the West. But the experience of these areas portend a worker shortage that will hit the entire country over the next 15 years.

The Department of Labor (DoL) projects a demand for 425,000 new nursing aides and 110,000 new home health aide jobs by the year 2000.¹² In fact, home care is among the fastest growing occupations according to the DoL, with a growth rate of 80 percent. As a society, we must embrace the challenge to develop a comprehensive long term care system. We can do this in part by developing a workforce stable, ready, and capable to meet its demands.

B. The Lack of Attention to the Problem and Possible Solutions

Public policy initiatives can dramatically alleviate the crisis among long term care workers or exacerbate it. Such policies include cost control efforts of the past five years and recently enacted legislation to promote quality in nursing home and home health care.

Cost containment The introduction of the prospective payment system under

¹⁰ Institute of Medicine, Improving the Quality of Care in Nursing Homes (National Academy Press, 1986), p. 11 and p. 90.

¹¹ "Home Health Aide Services for Medicare Patients," Office of the Inspector General (Dept. of Health and Human Services, April 1987), pp. 15 -16, and note 29, Lombardi, pp. 2 and 5.

¹² Bureau of Labor Statistics, National Industry - Occupational Matrix, 1986 -20, p. 524 and Projections 2000, BLS Bulletin 2302 (March, 1988), p. 51, pp. 56 - 57.

Medicare -- in which hospitals are reimbursed by patient diagnosis rather than for services actually provided -- has had a major impact on long term care workers. One immediate effect was to make it financially advantageous for hospitals to establish home care programs; there was a marked increase in such agencies after the institution of the prospective payment system. Hospitals also had an incentive to discharge patients as soon as possible. Subsequently both nursing homes and home health agencies reported sicker, more disabled patients. For example, a survey of Medicare-certified home health agencies by the National Association for Home Health Care found that a majority said they were serving increased numbers of sicker patients. At the same time, they faced increased denials of payment as a result of HCFA attempts to restrict eligibility.

States have also instituted cost-containment measures under Medicaid, which pays for almost half the total costs of nursing home care in the US each year. By changing reimbursement formulas, states have cut payments and have greatly limited annual increases: 2% increases are common, and some providers have received no increases from year to year. With labor constituting nearly 75% of the total costs, staffing levels and worker wages and benefits are hit hardest by these restrictions. For long term care workers, the results have been increased workloads, low wage increases, pressure for greater productivity, and, in the case of home care workers, the fallout from uncertainty over Medicare reimbursement.

Quality of Care In 1987, Congress enacted nursing home reform legislation (included in PL 100 -203). One provision eliminates the distinction between skilled nursing facilities and intermediate care facilities. An important difference between these designations concerns minimum staffing requirements.¹³ Thousands of nursing homes will need to hire new licensed personnel at the very time when a growing shortage of nurses is creating intense competition for their services. First priority for improvements in wages and benefits is thus likely to be directed to RNs and LPNs over the next few years.

A second key provision of the legislation establishes training standards for new nursing aides, who must have a minimum of 75 hours of training during the first four months of employment, after which they must be able to demonstrate competency. This requirement could serve to benefit many aides through upgraded training that can support a career ladder. On the other hand, it could screen out those who have difficulty with written tests or who

¹³Skilled nursing facilities must have an RN Director of Nursing, one (1) RN on the day shift and one (1) licensed nurse (RN or LPN/LVN) on the other shifts; intermediate care facilities must have an RN consultant four hours per week, and one licensed nurse on the day shift. In 1986, fully half of the facilities certified by the federal government did not meet the skilled nursing facility standards. However, as of October 1990, all nursing homes participating in either Medicare or Medicaid must meet them.

need English language training or basic literacy as a prerequisite for classroom training.

The Pepper Commission, a bipartisan group of Members of Congress who are leaders on health issues and community health care leaders, was charged by Congress with the responsibility of producing recommendations on access to long term care and acute health care services. A draft summary of those recommendations was released on March 2, 1990 and a final report was released in September, 1990 (see Appendix A).

Lou Glasse, President of the Older Women's League (see Appendix B) presented testimony urging that the Commission address the worker problem. However, the Pepper Commission initial recommendations do not include any strategies for grappling with the basic underlying problem. Secretary of the Department of Health and Human Services (HHS), Dr. Louis Sullivan, has instructed the Under Secretary of HHS to forward recommendations to him no later than October, 1990. And the Advisory Council on Social Security, chaired by Deborah Steelman, has been charged with developing "recommendations for more stable health care financing for the aged, the disabled, the poor, and the uninsured."

In sum, long term care workers are in demand now, and many more will be needed later, as the elderly and disabled population grows. But for various reasons, including low wages, inadequate benefits, poor training, and poor supervision, the supply of long-term care workers is unstable. Recent federal policy has had contradictory implications for these workers. While the implementation of the prospective payment system for hospitals under Medicare initially helped create more home health aide jobs, recent Medicare and Medicaid reimbursement policies have resulted in reduced long term care worker staffing levels, and relatively low wages and benefits, thus exacerbating the problem. Similarly, while nursing home reform legislation included upgraded training requirements for nursing home aides, new requirements for nurse staffing levels could mean that aides' needs will be ignored.

Fortunately, current efforts to revamp the health care financing system present a window of opportunity to address the needs of long term care workers more adequately. However, any policy revisions must be supported by adequate research into the dilemmas of long term care workers and solutions to their problems.

II. The Research Agenda

A. Developing the Research Agenda

To develop an agenda linking research on improving the status of long term care workers to public policy initiatives, the Older Women's League (OWL) convened a task force of prominent researchers and practitioners in the area of long term care. (Members of the task force are identified on page iii). The task force met twice in Washington D.C. on February 23-24, and October 27-28, 1989. During the second task force meeting we invited representatives from a broad base of women's, aging, labor, and church organizations to join the researchers in a roundtable brainstorming session around the problem.

Based on the experience of the task force members and the useful insight of all who participated in the roundtable discussion, the following are suggested areas of additional research which should shed more light on how to provide long term care workers with greater job satisfaction, thereby decreasing worker turnover and increasing quality care.

The following summary identifies areas of proposed research, in order of priority, established by members of the Advisory Board and OWL. Priorities were established with the goal of furthering a public policy agenda which addresses the needs of long term care workers.

B. Recent and Ongoing Research in the Area

In very recent years, the federal government and private foundations have begun to fund research projects to analyze existing data on long term care workers and demonstration projects to evaluate the effectiveness of various intervention strategies. However, much more information is needed to understand just who these workers are; why they stay in the field; or why they leave.

To date, no intervention strategy has been tested that would improve significantly the situation for long term care workers and that could be maintained over a period of time without the assistance of some outside force, such as foundation funding.

The following summary reflects the research currently underway on long term care workers:

HOME CARE

--Margaret MacAdam of the Bigel Institute for Health Policy, Brandeis University is doing a project on home care workers as part of the large Quality of Care study that

Bob and Rosalie Kane are conducting for the U.S. Department of Human Services (HHS), Office of Research and Development of the Health Care Financing Administration. The home care project consists of four parts. One is a sample survey of home care agencies in 20 states. Another is an analysis of Census Bureau data from the Current Population Survey for years 1986-88 on home care workers. A third is a labor economics study comparing long term care workers to other low income women and a comparison in two states with completely different labor markets of paid caregivers versus unemployed women to learn what would attract these unemployed women to home care. And the final segment is the compilation of a best practices guide of home care agencies with low turnover rates and high worker satisfaction and quality of care. The multi-million dollar grant began in October 1989 and will run for 42 months.

--Penny Feldman of the Department of Health, Policy and Management, Harvard School of Public Health completed in 1988 a three-year demonstration project funded by the Ford Foundation to examine the home care labor market in four sites and to use specific intervention strategies to improve the employment conditions for home care workers. The four sites were San Diego, Milwaukee, Syracuse, and New York City. The intervention strategies included wage increases, training and support, and guaranteed hours of work. The study found that, depending on the project, program participants were 21% to 44% more likely than their control group counterparts to be on the job one year after the projects began.

--Marge Cantor of the Third Age Center, Fordham University is in the process of completing a study on factors relating to job-related stress and strain among home care workers of the frail elderly in New York City funded by the United Hospital Fund and Morgan Guaranty Trust. The report will provide two levels of recommendations; first at a micro-level to reduce stress and strain within home care agencies in their delivery of services and secondly, at a macro-level in dealing with the financing of home care, the immigration issues, and the overall case management scheme. Preliminary findings indicate that a significant number of home care workers experience financial strain and stress associated with providing care.

--Rebecca Donovan of the Hunter College School of Social Work recently completed a survey project funded by the City University of New York and Local 1199, Drug, Hospital, and Health Care Employees Union, examining the home care workforce in New York City. The survey looked specifically at the work stress and job satisfaction of home care workers. It found that most home care workers were dissatisfied with their wages and benefit levels; that many experienced stress caused by excessive workloads; and that this stress affected their job satisfaction and sense

of well-being.

--Rick Surpin and Fred Grumm of the Cooperative Home Care Associates convened a Home Care Work Group, consisting of a broad range of representatives from service agencies, labor, client advocacy groups, and universities, to make recommendations on improving the home care situation in New York City.

INSTITUTIONAL CARE

--Rosalie Kane of the University of Minnesota recently completed a survey funded by the Retirement Research Foundation that looked at the level of satisfaction of nursing home residents and its impact on the delivery of care. The study surveyed workers and residents of nursing homes in Los Angeles, Santa Fe, Little Rock, New York City, and Minnesota.

--Michael Smyer at Penn State University is completing a project funded by the Retirement Research Foundation on nurses aides' attitudes toward their jobs, looking at job descriptions and the tasks of workers. Intervention strategies were used in three Pennsylvania nursing homes: skills training in providing mental health care; job redesign to provide aides with greater responsibility; and restructuring reporting so that aides take part in care plan design. One nursing home was the control and no intervention strategy was employed. The project also included a seminar in February on how to improve the quality of care in nursing home care attended by researchers and providers.

--Charles Litz of the University of Pittsburgh compiled recommendations on the delivery of care in nursing homes and intermediate care facilities, funded by the Retirement Research Foundation.

--Deborah David of the Gerontology Center, San Jose State University is producing training material, with Florida International University, for nurses aides to sensitize them to how residents feel regarding maintaining a certain degree of autonomy. This project was also funded by the Retirement Research Foundation.

--Sally Lusk of the University of Michigan School of Nursing recently completed a survey of nursing homes near Ann Arbor, Michigan for the National Institute for

Safety and Health (NIOSH) of the Department of Health and Human Services and reported on major problem areas, including the status of the nurses aides. Problem areas included 1) pay and benefits; 2) understaffing and overwork, resulting in burnout and a high turnover rate; 3) communication between aides and supervisors; 4) communication between aides and patients; 5) lack of career development and job advancement opportunities; 6) environmental factors, including lack of space in patients' rooms, poorly maintained equipment, and lack of supplies; 7) lack of knowledge and training on handling patients with infectious diseases.

--Catherine Hawes of the Research Triangle Institute is conducting a study, funded by the Office of the Assistant Secretary of Planning and Evaluation (ASPE) of the U.S. Department of Health and Human Services, of board and care facilities. The staff will be surveyed to obtain descriptive data on wages, length of service, benefits, etc.

--Marian Caudill of the University of Washington recently completed a study of nurses aides in Washington State that examined the length of stay of nurses aides in their jobs--specifically what factors lead to aides staying in their jobs and what factors contributed to their leaving. Several factors, including salary, age, lower levels of education, longer intervals of assignment to patient groups, availability of benefits, and decisionmaking autonomy were favorably related to longer periods of employment.

MISCELLANEOUS

--Jane Aumen of Wyatt has just completed an analysis of the home care system in British Columbia, Canada for the Canadian government. While the Canadian health care system is able to provide all citizens with access to acute care services, their long term care service delivery is not as well developed. A shortage of long term care workers also exists in Canada, as well as the problems of low wages, turnover, and adequate training. Ms. Aumen will now be embarking on the same type of study of home care in the province of Ontario.

--The Pennsylvania Care Management Institute is being funded by Pew Charitable Trusts and the William Penn Foundation to develop training curricula for case managers of long term care services in hospices, hospitals, nursing homes, and home care. The project will take an interdisciplinary approach and will look at building a career path for long term care workers to become case managers. The study will focus on five counties in New Jersey, Pennsylvania, and Delaware.

C. Areas of Proposed Research

1. Market area study of nursing home aide workforce.

Nursing home aides face many of the same problems faced by home health aides, including low pay, inadequate benefits, and poor training, among others. To date, very little research has focused on the plight of the nursing home aide. Much of the research that has been done has focused on home care workers, particularly in New York State. This is understandable given that New York State spends approximately 78 percent of all the Medicaid dollars devoted to home care nationally. Of the state's allocation, approximately 73 percent is spent in the city. Given the probable federal expansion of long term care coverage, more research needs to be completed examining the different demands and problems by work site.

While the Bigel Institute for Health Policy at Brandeis University will be conducting a wide market area study of the home care work force as part of the Quality of Care study at the U.S. Department of Health and Human Services (HHS), no institution has conducted such a wide market study of aides in nursing homes.

Given the many similarities between the two workforces--home care aides and nursing home aides--a study to match the Quality of Home Care is very much needed. Even though HHS conducts the National Nursing Home Survey each year which produces over one hundred volumes of data on the conditions of nursing homes throughout the country, this survey does not look at the status of nursing home aides. With this mechanism already in place to monitor nursing homes from coast to coast, it would be relatively easy to have the surveyors conduct interviews with the aides.

Such a market area study should include:

--A work site selection representing a geographic, rural/urban, and liberal/conservative state Medicaid program mix. Project should include examination of both nursing home and home care workers in the selected areas;

--A description of the socio-demographic choices of the work force; e.g., in some areas the workforce will be predominantly women of color, possibly with language barriers; age of workforce may vary, etc.;

--A description of wages, benefits, work patterns, length of current stay, and other conditions of work across different work sites;

--A national survey as to why workers stay in the field or why they might leave and what they believe would improve their job satisfaction. Discrete surveys like this in specific geographic areas have been conducted, but no comprehensive survey has been conducted.

2. Survey to Determine Similarities and Differences between Home Care Workers and Nursing Aides.

Up to this point, researchers have not included both home care workers and nurses aides in the same sample to be interviewed despite the similarity in training, status, wages, benefits, retention rates, etc. Researchers, themselves, clearly specialize in one area or the other. The recent report of the Older Women's League is the most comprehensive analysis of the two fields examined as a whole.

Given the connection between the two fields, we believe that a comprehensive study looking at both groups together might lead to greater insight into the paraprofession of providing long term care assistance. Workers themselves move easily from nursing home to home care. The new training regulations that were promulgated pursuant to enactment of the Omnibus Budget Reconciliation Act of 1987 (OBRA) moved along two separate tracks--a seemingly ineffective and wasteful way to deal with implementing the training requirements.

For many years the two professions were seen in competition with each other. Increasingly, even the providers do not view the field that way anymore. Much could be learned from looking at the two sets of workers in tandem.

Any survey should be constructed to yield answers to differences and similarities in training requirements; daily tasks performed; job satisfaction; retention rates; supervision and responsibilities.

3. A series of demonstration projects testing various intervention methods.

In the past, federal and state health care legislation has included appropriations for demonstration projects, which, if successful, may become models for other projects, and which may ultimately become fully integrated into health care financing programs. While various intervention projects were mentioned above as recently completed or ongoing, much more needs to be done. The demonstration projects should look at a number of different work life interventions designed to decrease worker turnover and increase job satisfaction, beginning with a representative national survey of workers-- both home care and nursing home aides-- to determine why they stay in the field and what they think could improve their work lives. Such interventions may include:

- Providing child care services at or near the nursing home as a benefit to the workers (and the residents) and information and referral services for home care workers.

- Creating a career ladder and support and supervision for home care workers by establishing a supervisory level that would provide site visits to homes and coordination of work days for the worker. Another level above the field supervisor could be the case manager to coordinate services to the clients. The New York Home Care Group recommended creating a career ladder such as this. A career ladder can also be created for nursing aides by providing them with greater responsibilities and/or providing them with incentives to go to school to become LPNs. The Penn State study restructured aides' job description, but encountered problems because the supervisory staff became resentful of the increased responsibility of the aides. Another demonstration project should be tried with greater emphasis on sensitizing the nursing staff to the benefits of having shared responsibility with the aides.

- innovative delivery systems, such as the On Lok project in San Francisco, should be designed to look at long term care in a group or community setting, i.e. public housing or life care communities. This "cluster care" would allow one worker to serve many clients and might lead to greater job satisfaction and also help to be part of a career ladder. The On Lok, project was designed to integrate the long term care worker into the service delivery team and to maximize the efficiency of service promotion;

- Schemes for "self financing" work life improvements--e.g., shared aide experiments

--beginning home care at an earlier stage where it is less expensive to see if this avoids more costly institutionalization later.

4. State-by-state survey of how well each state is meeting its training requirements for both home care and nursing home aides under OBRA.

The OBRA home care training requirements went into effect in February and the nursing home training requirements are scheduled to go into effect in October. A survey of how well and how the states have met the requirements would be very useful, especially in regard to any conclusions that could be drawn regarding changes in the quality of care and feelings of job satisfaction on the part of the workers. Survey results could be used to support changes in monitoring procedures or changes in regulatory language.

5. Study of how federal job training and employment programs are used to train long term care workers.

Several federal job training programs created to provide job training and placement assistance to low income workers could be used to recruit and train long term care workers and to improve their wages and benefits. For example, the Job Training Partnership Act, which funds employment and training programs for economically disadvantaged adults and youth, and Senior Community Service Employment Programs (SCSEP), (Title V of the Older Americans Act), which provides minimum wage jobs for individuals age 55 and older, could be used to train additional long term care workers. An analysis should be completed to show how the JOBS program under the newly enacted Family Support Act, the federal and state vocational education programs, JTPA, and Title V of the Older Americans Act are being or could be used to recruit and train long term care workers and to improve the wages and benefits of these workers. Special emphasis should be placed on answering the question whether persons in these jobs can stay off welfare.

6. Study of the profitability of providers in the nursing home and home care industries and their use of pools of temporary workers.

This study would help to determine how much of workers' low wages and benefits are due to low reimbursement levels of Medicaid or to inefficient management by providers. This data would particularly useful in states where workers' wages are being increased through wage pass through legislation, whereby a state increases Medicaid reimbursement levels so that the increases go straight to the workers, in assuring accountability for how the funds are used. A study of the use of temporary workers would also provide useful insight

into quality of care and the status of regular aides.

7. An analysis of the role of state policies that specify the responsibilities of various professional and paraprofessional workers.

The New York City Home Care Work Group cited the definition the state of New York uses for various workers as a problem in allowing workers to perform their jobs effectively. Often these limiting definitions lead to a client having several workers and frustration on the part of the client and the worker. In New York the differences in responsibilities for each title are only marginal and are more an indication of different funding sources than different skills or experience. While some studies of the New York system have been conducted, it would be useful to conduct similar evaluations in other states, with the goal of creating standard definitions for the purpose of comparing wages, benefits, etc. and professionalizing the occupation.

Other research possibilities which were explored but not given as high of a priority include:

8. State-by-State survey to determine:

--what assistance is available to train immigrants in both home care and nursing home care

--what the state has done and is planning to do to entice workers into the home care and nursing home care fields

--what the state has done to improve the status and conditions of working for these long term care workers.

9. An analysis of union organizing of workers throughout the country

Historically, unionization of previously unorganized workers has achieved improved wage and benefit standards for those workers. An analysis should focus on those geographic areas where long term care workers have successfully organized and on whether unionization has in fact improved working conditions.

10. Pay equity analysis

Home care, nursing home, and hospital aides have rarely been considered as a discrete group of health care workers, although they perform essentially similar tasks. A study of the wages of each group of these health care services workers should be undertaken, analyzing whether they are in fact being paid equally for equal work.

11. Study of using community colleges and vocational education programs for continuing education programs (not career ladder development, just job enhancement training)

--Kansas State University is trying to get such a project funded; the hitch is that there is no career ladder & funders fear that education as simply job enhancement is not worthwhile.

12. Comparison of vendor system to individual provider or mixed mode system as to impact on status of worker13. Study impact of race on job satisfaction

III. Beyond the Research Agenda

In compiling the research agenda, the task force identified successful campaigns to improve conditions for long term care workers. Some of these campaigns rely on legislative changes at local and state levels, while others evolve from the private sector. The following strategies represent models upon which researchers, policymakers, providers, and consumers can draw.

A. Wage Pass Through Legislation

Wages are the largest component of patient care cost. As is true in many other settings, the quality of service is inexorably tied to the caliber and motivation of the persons providing that service. The wages of persons providing care in nursing homes and in home settings are generally low. Many workers earn less than employees in fast food restaurants. RNs, LPNs, and aides in nursing homes make less than their colleagues in hospitals and home care workers make even less than nursing home workers.

Almost half the residents in nursing homes are Medicaid recipients. Therefore, one way to increase the wages of nursing home personnel is to increase Medicaid reimbursement levels, which are notoriously low, and tie this increase directly to wage increases for workers. This method of increasing wages does not work as well in the home care setting, since Medicaid does not fund a great deal of home care services.

Several states have adopted wage pass through initiatives: California, Michigan, Maryland, Wisconsin, Minnesota, Connecticut, and Pennsylvania. The approaches in these states has varied widely, because of the different state reimbursement systems under the Medicaid program.

What occurred in Michigan is a good example of what can be accomplished with a wage pass through. The Service Employees' International Union, Local 79, was successful in mounting a legislative campaign and organizing workers around achieving a 50 cent increase in hourly wages for nursing home workers in 1989.

The legislative language was:

"(2) The aggregate increase in rates for nursing homes and chronic care units and county medical care facilities shall be 4% effective October 1,

1989. It is the intent of the legislature that at least 50% of this aggregate increase in rates shall be used for a wage and benefit pass-through to direct patient care staff, based upon a plan developed by the department. The rate increase for enhanced wages and benefits shall be provided to those facilities which make application for it to fund the medicaid program share of wage and benefit increases up to 50 cents per employee hour. Nursing facilities shall be required to document that these wages and benefit increases were actually provided."

The legislation could have been strengthened by:

--Requiring audits to be conducted for 50% of all facilities, and that additional audits be mandated where a prima facie case can be made that earmarked funds for employees were not passed on.

--Requiring that providers bargain with collective bargaining agents where such relationships exist.

--Including clear language that all increases be established in addition to current wage scales and start rates, in addition to funds and increases already achieved through past COLAs.

--Establishing harsh penalties for failure to provide the full wage pass through to employees.

Appendix C contains the literature SEIU used in its campaign for the wage pass through and the bulletin from the Michigan Medical Assistance Program that explains to providers how the wage pass through is to work.

Appendix D contains a copy of a federal bill, H.R. 1649, introduced by Representative Doug Walgren, that would institute a wage pass through program for the federal Medicaid program.

B. Wage Increases through Community and Union Action in Contract Negotiations

The battle fought and won in New York City is by far the best example of how successful this type of community/union action can be. As the result of a major combined union organizing--public relations campaign, home attendants in the New York City Human

Resources Administration Home Care Services Program won a significant increase in wages and benefits in 1987. Through public hearings and skillful use of the media to humanize the workers, the Association of Federal, State, County, and Municipal Employees, Council 1707, (AFSCME) was able to reach this agreement with the city:

--Effective December 1, 1987, the hourly wages of all workers will increase by \$.85 an hour.

--Effective July 1, 1988, all workers who have worked at least 80 hours a month for two consecutive months will be eligible for family health insurance which will cover: 365 days of hospital care; major medical (inpatient physician services); full coverage for physician visits to one of 600 panel doctors or \$25 reimbursement for other doctor visits.

--Effective July 1, 1988, weekend workers will receive an extra \$.50 an hour.

--Effective July 1, 1988, 24-hour workers will receive an extra \$6.25 a day.

--Effective September 16, 1988, the hourly wages of all workers will increase by \$.40 an hour.

--Effective April 1, 1989, all eligible workers will receive dental, vision, and prescription (workers pay one-third the cost of prescription drugs) benefits for themselves and their dependents.

--Effective April 1, 1989, 24-hour workers will receive an additional \$3.75 a day.

--Effective April 1, 1989, weekend workers will receive an extra \$.60 an hour.

--Effective July 1, 1989, all workers will receive an additional \$.50 an hour.

While the New York City success cannot be replicated everywhere (one reason for New York's success was that home care is an entitlement program there), this is an example of what community action and union organizing can achieve.

C. Successful Provider Programs in Meeting Workers' Needs

Concerned about quality of care and the high cost of worker turnover, several providers have implemented programs to improve the status of the long term care worker.

--Caremet, a Warsaw, Indiana-based facility, utilizes a career ladder program. An employee educational assistance program enables nursing aides and LPNs--who have worked in a Caremet facility for at least one year--to receive nursing school financial assistance. If a nursing aide wants to become a LPN, Caremet loans the aide the money for the program, which is about \$2,300. When the aide completes the program, (s)he "works off" the loan at the rate of \$200 a month for one year.

--Meridian Healthcare in Towson, Maryland has employees participate in an annual employee attitude survey to identify employee needs and concerns; provides in-service training courses that stress supervisory skills; and has small groups of employees meet to identify and develop solutions to work-related problems.

--ARA Living Centers, a Houston-based company, has instituted employee recognition days, whereby at the end of the year, administrators, doctors, activity professionals, nurses, nursing aides, program specialists, and food service employees will all have been recognized with special days. Posters are designed for each recognition day.

CONCLUSION

From our 18-month project of gathering information on existing research in the area of long term care workers and of sensitizing other women's, aging, and church organizations to the problems faced by these workers, we have learned the following:

1. Research published to date and research still in progress confirms anecdotal impressions that low wages, inadequate benefits, excessive workloads, poor training, supervision, working conditions, and job-related stress cause high turnover among both home health and nursing home aides.
2. To date, most research done in on long term care workers has focused on home health aides. Future research should focus on the problems encountered by nursing home aides, also. A market area study of the nursing home workforce and a study of states' compliance with new aide training requirements would help fill this gap.
3. Future research should focus on similarities between these two categories of workers, with a view to streamlining planning for future needs and funding.
4. Demonstration projects testing the success of various intervention methods in

alleviating the long term care worker shortage should be tested.

5. Public policy should encourage successful passage of state level legislation, such as wage pass-through legislation; wage and benefit increases; and innovative provider programs designed to attract and retain long term care employees.

**PRELIMINARY RECOMMENDATIONS
TO THE CONGRESS**

BY

THE PEPPER COMMISSION

**U.S. BIPARTISAN COMMISSION ON COMPREHENSIVE
HEALTH CARE**

Senator John D. Rockefeller IV, Chairman

“Access to Health Care and Long-Term Care for All Americans”

March 2, 1990

(Revised 3/8/90)

Summary: Recommendations on Access to Health Care

THE PEPPER COMMISSION PROPOSAL ASSURES HEALTH CARE COVERAGE FOR ALL AMERICANS THROUGH A JOB-BASED/PUBLIC SYSTEM.

Smaller Employers Businesses with 100 or fewer employees are encouraged to provide health insurance for their employees and non-working dependents.

- * To make insurance more available and affordable:
 - The private insurance market is reformed.
 - A minimum package is available.
 - Tax credits/subsidies for certain small employers are available.
 - Self-employed and unincorporated businesses can deduct 100% of their premiums.
- * If employers purchase coverage and achieve a specified coverage target, there is no requirement to provide private insurance or participate in the federal public health insurance plan ("public plan").

Larger Employers All businesses with more than 100 employees must provide private health insurance (for a specified benefit package) or contribute to the public plan for all employees and non-working dependents.

Public Plan The public plan will cover employees and dependents that contribute and non-working individuals who buy in or are subsidized.

- * The plan replaces Medicaid for the specified services and pays providers according to Medicare rules.
- * The fully phased-in plan is financed and administered primarily by the federal government, although states can opt to administer it.

Benefits The minimum benefit package includes primary and preventive care, physician and hospital care, and other services. Services are subject to cost-sharing, with subsidies for low income people and limits on out-of-pocket spending.

Costs, Quality, and Delivery Systems System reforms include measures to contain costs, assure quality and initiate innovative delivery systems for the underserved.

Phase-In For both administrative and fiscal reasons, the plan will be phased in, beginning with making coverage available for children and pregnant women through the public plan.

Universal Coverage At full implementation, all Americans will be required to have health insurance through their employer or the public plan.

Summary: Recommendations on Long-Term Care

THE PEPPER COMMISSION PROPOSAL PROVIDES ALL AMERICANS COVERAGE FOR HOME AND COMMUNITY-BASED LONG-TERM CARE SERVICES AND PROTECTION AGAINST IMPOVERISHMENT IN NURSING HOMES.

Home and Community-Based Care

- * Severely disabled persons of all ages are eligible for social insurance for home and community-based care.

Nursing Home Care

- * The plan establishes a Nursing Home Program (NHP) for nursing home care to provide an ample floor of financial protection, ensuring that no one faces impoverishment.
- * In addition, all nursing home users are entitled to social insurance for the first three months of nursing home care. This "front-end" insurance allows people who have short stays to return home with resources intact.

Financing and administration

- * The federal government finances the home and community-based care program and the three-month "front-end" nursing home care.
- * The federal and state governments share financial responsibility for the NHP.
- * All three components of the plan are administered by the states according to federal guidelines.
- * States are responsible for cost containment, quality assurance and consumer protection within federal standards.

Private sector role

- * Private long-term care insurance fills gaps not covered by this plan, subject to government standards and oversight.
- * The federal government encourages the development of private long-term care insurance through clarification of the tax code.

Phase-In

- * For both administrative and fiscal reasons, the benefits will be phased in over time.

PEPPER COMMISSION RECOMMENDATIONS ON ACCESS TO HEALTH CARE

Structure of Job-Based/Federal Public Health Insurance Plan

1. Employer Responsibilities (in businesses with more than 100 employees; in smaller businesses only if a specified coverage target is not met):

- * All businesses are required to provide private health insurance for at least the specified benefit package to all employees (and non-working dependents) or contribute to the public plan on their behalf.
- * If employers choose to provide private insurance, they must pay at least 80% of the premium for full-time workers and their non-working dependents and a share of the premium for part-time workers and their non-working dependents.
- * Alternatively, employers may contribute to the public plan for coverage for their employees and non-working dependents. The contribution will be equal to a percentage of payroll, set at a level to encourage employers who now purchase private insurance to retain that coverage and to establish a fair balance of additional coverage responsibilities between the private and public sectors.
- * Employers may choose to purchase private insurance for their full-time workers and contribute to the public plan for part-time workers.

2. Individual responsibilities

- * All workers receive the specified benefit package through their own employer, although they may receive extra benefits from their spouse's employer. Rules, consistent with tax policy, determine the plan to which children are assigned.
- * Individuals pay up to 20% of the private insurance premium.
- * To participate in the public plan, working individuals pay a percentage of wages as their share of the premium. Self-employed and non-working individuals pay the cost of the plan, subject to their ability to pay. People with incomes below 100% of poverty (and pregnant women and children to age six below 185% of poverty) pay nothing and people with incomes below 200% of poverty would pay no more than three percent of income for the premium for adults or one percent of income for the premium for children and pregnant women.
- * Premiums and cost-sharing for low income people, whether covered by the public plan or private insurance, are subsidized by the federal government. Individuals or families whose income is under 100% of the federal poverty level pay no premiums, deductibles or coinsurance. Individuals or families with income up to 200% of poverty, at a minimum, pay premiums, deductibles and coinsurance on a sliding scale.

- * At full implementation, individuals must obtain health insurance through their employer or the public plan.

3. Public Plan

- * At full implementation, the public plan is financed and administered primarily by the federal government. As under Medicare, insurers may administer claims and may, under contract, offer managed care options. States also may administer claims.
- * The public plan pays providers for the specified services with rates set according to the rules of the Medicare program.
- * The public plan subsumes Medicaid for the specified benefits. Medicaid remains intact for all services not covered by the package.
- * Participation in the public plan is financed through:
 - employer contributions
 - individual contributions
 - federal revenues
 - state contributions equal to Medicaid expenditures for covered services, adjusted for general inflation.

4. State Role

- * State governments no longer have responsibility for providing the specified benefit package for their low income residents. The new public plan replaces Medicaid for those services. Medicaid is retained for services not included in the package.
- * States contribute to the public program as specified above.
- * A state, at its option and subject to federal rules, can administer the public plan. All aspects of the administration must be conducted through a new agency which is unconnected to the welfare or Medicaid departments.
- * States retain the responsibility for regulating financial stability of insurers.

5. Specified Benefit Package

- * Basic services, including hospital and surgical services, physician services, diagnostic tests and limited mental health services (45 inpatient days and 25 outpatient visits).
- * Preventive services, including prenatal care, well-child care, mammograms, pap smears, colorectal and prostate cancer screening procedures and other preventive services that evidence shows are effective relative to cost.

- * Early, periodic screening, diagnosis and treatment services (EPSDT) are included for children in the public program. Privately insured families can buy this coverage for their children from the public plan at cost (or at a subsidized rate for families under at least 200% of poverty).
- * Deductibles are \$250 for an individual and \$500 for a family. Coinsurance is 20% for all services except prenatal care, well-child care, and other preventive services, which have no coinsurance, and the limited outpatient mental health benefit which has a 50% coinsurance. The maximum, annual out-of-pocket expense per person or family is \$3,000.
- * One year after the effective date of this plan, the Office of Technology Assessment shall report to the Secretary on an assessment of the cost-effectiveness of prescription drugs for the purpose of inclusion in the benefit package as a preventive service.

Assistance for Small Business

1. Insurance reforms and a minimum benefit package will make obtaining private insurance for small groups more predictable and affordable. (See below.)
2. To stimulate voluntary coverage, employers with fewer than 25 workers and average payroll below \$18,000 will be eligible for tax credits/subsidies for 40% of the cost of health insurance for workers and their dependents. After the tax credit/subsidy for employers of fewer than 25 employees ends, businesses of ten employees or less, previously eligible for the credit, who are at extreme financial risk, would be allowed to purchase coverage from the public plan at a percentage of payroll, set consistently at a relatively low rate to ensure affordability.
3. No employer with 100 workers or fewer would be required to purchase coverage or contribute to the cost of coverage if coverage targets were met voluntarily. (See phase-in schedule for details.)

Insurance Market Reform

1. For all employment-based health insurance:
 - * No pre-existing condition exclusions.
 - * No denial of coverage for any individual in the group.
2. For those who wish to sell a health insurance product to employers in the small group market new rules would apply:
 - * Guaranteed acceptance of all groups wishing to purchase insurance.
 - * Insurers set rates on the same terms to all groups in specified areas.

- * Rates may not be increased selectively for any group enrolled in a plan.
- * Enrollment for a specified minimum period.
- * States are restricted from regulating the content of health insurance benefits, but benefits are standardized, to the extent possible, across carriers. At least one basic benefit package must be offered by each insurer in the small group market.
- * If managed care plans are available to larger employers in the area, then such plans must also be offered to small groups.
- * A self-financed voluntary reinsurance mechanism through which insurers could reinsure high-risk persons or groups would be established.

Quality Assurance

1. The federal government should develop and implement a comprehensive national system of quality assurance which includes:
 - * The development of national practice guidelines and standards of care, already begun by the newly created Agency for Health Care Policy and Research. Physicians and physician organizations should be widely utilized in developing and reviewing practice guidelines and parameters.
 - * The development and implementation of a uniform data system that covers all health care encounters, regardless of payment source or setting. These data would provide a common foundation for all payers' quality assessment activities and for examining the effectiveness of medical care and identifying health policy and research concerns.
 - * The development and testing of new, more effective methods of quality assurance and assessment.
 - * The development and oversight of local review organizations that have skills in data integration and analysis, quality assessment and quality assurance.
2. The Prospective Payment Assessment Commission and the Physician Payment Review Commission will be directed to convene experts, providers, lawyers and consumers to study and conduct demonstration projects related to medical malpractice reform in order to make recommendations to Congress on actions to be taken on the federal level. The appropriate committees of jurisdiction in Congress should also hold hearings on the malpractice issue, and the access legislation should incorporate professional liability reform.

Cost Containment Initiatives

1. Insuring all Americans through a job-based/public program and reforming the private insurance market will distribute the costs of insurance more fairly by:
 - * Reducing the cost-shift that now occurs from the uninsured to the insured population.
 - * Reducing the cost-shift that now occurs from employers who do not provide insurance to employers who cover their workers and dependents.
 - * Assuring small business access to a minimum benefit package at a predictable rate, regardless of employees' health status.
2. Adoption of a quality assurance strategy (described above) and reform of the medical malpractice system will assure greater value for the dollar in the delivery of medical services.
3. Measures to promote efficiency in provider payment would include:
 - * Cost-sharing in the minimum benefit package that makes consumers sensitive to price.
 - * Insurance reform that leads insurers to compete around efficient service delivery, rather than for "good" risks.
 - * Extending "managed care" to small employers and including "managed care" as a means to provide the minimum benefit package in private insurance and the public plan.
 - * Extending Medicare payment rules to the public program, which, in turn, serves as a model for private insurance.
 - * Recommending that the Prospective Payment Assessment Commission and the Physician Payment Review Commission assess cost experience and initiatives to contain costs in the public and private sectors and make periodic recommendations to the Congress on federal initiatives.

Delivery Issues

1. Expanding health care insurance coverage should reinforce -- not replace -- support for primary care delivery systems targeted at the poor and underserved. Organized primary care providers (e.g., local health departments and community health centers) should be recognized and reimbursed by private and public payers on the same basis as all other providers.

2. The federal government should:

- * Promote an adequate supply and appropriate mix of personnel and facilities for underserved areas and populations through mechanisms including:
 - Provider payment methods in public programs that promote the availability of primary care practitioners and facilities and assure access to other needed services;
 - Special initiatives (such as the National Health Service Corps and other financial incentives) to attract a range of providers (physicians and other practitioners) to underserved areas, and to assist such providers through mechanisms such as professional backup systems and support networks for rural providers (e.g., telecommunications with other professionals and facilities, mobile medical services).
- * Support local efforts to develop outreach and facilitating services, such as, health education, transportation, home visiting, and translation services -- preferably linked to health care delivery programs -- to facilitate access to services and to encourage patients to seek and continue participation in health care.
- * Support local efforts to reduce organizational and bureaucratic barriers to access through efforts such as the coordination and/or co-location of medical, welfare and social services (e.g., medical referrals, nutrition counseling and eligibility determinations for welfare and housing programs).
- * Undertake and support research and evaluation efforts to determine the effectiveness of primary care models and services aimed at addressing the needs of underserved communities.
- * Support programs of health promotion, disease prevention, risk reduction and health education toward the reduction of excess morbidity and mortality and toward the increase of healthy lifestyles. Federal support for such programs should total at least \$1 billion annually beyond current federal efforts.
- * Support an effective continuum of care, including short-term hospital-based and/or longer-term community based alcoholism and other drug treatment services.

Phase-In Schedule

Phase I (Year 1)

- * Institute insurance reform.
- * Allow all uninsured pregnant women, and children ages 0-6, to enroll in public plan, if they are from non-working families or families of workers whose employers do not provide coverage. Costs would be subsidized, according to ability to pay, at least for those with family incomes below 200% of poverty.
- * Begin to improve reimbursement to providers for persons now served by Medicaid.

Phase II (Year 2)

- * Firms with fewer than 25 workers and average payrolls below \$18,000 become eligible to receive a 40% tax credit/subsidy for cost of coverage if they provide it. The subsidy would be available for five years from the year Phase II is instituted.
- * The public plan is made available to uninsured children up to age 18 (those from non-working families or families where workers' employers do not offer coverage). Subsidies would be available based on ability to pay, at least for those with family incomes below 200% of poverty.

Phase III (Year 3)

- * Firms with 100 or more workers are required to provide private insurance coverage or contribute a portion of payroll toward the cost of covering employees and dependents in the public plan.

Phase IV (Year 4)

- * If 80% of uninsured employees of firms with 25-100 workers (as of Year 1) are not insured through their employers, along with their dependents, all employers of this size are required to provide private insurance coverage or contribute toward the cost of coverage in the public plan.
- * If coverage target is met, the Secretary of Health and Human Services is required to recommend to Congress ways to increase coverage options for employees (and their non-working dependents) who are not covered by their employers.

Phase V (Year 5)

- * If 80% of uninsured employees of firms with fewer than 25 workers (as of Year 1) are not insured through their employers, along with their dependents, all employers of this

size are required to provide coverage or contribute toward the cost of coverage in the public plan.

- * If coverage target is met, the Secretary of Health and Human Services is required to recommend to Congress ways to increase coverage options for employees (and their non-working dependents) who are not covered by their employers.
- * All non-working adults are covered through the public plan.

Phase VI (Year 6)

- * Congress considers the Secretary's recommendations.
- * All individuals are required to have insurance coverage through their employers or through the public plan.

Phase VII (Year 7)

- * Eliminate explicit subsidy to small firms with low wage workers, except for firms of ten employees or less at extreme financial risk.

Revenues for Health Care

- A. Although some of the revenues necessary to support the above recommendations could come from savings achieved elsewhere in the federal budget, the Commission is committed to raising whatever additional revenues are necessary.
- B. In considering what revenue options to adopt, the Commission recommends that the choice be guided by the following three criteria:
 1. The final tax package ought to be progressive, requiring a higher contribution from those most able to bear increased tax burdens. That is, families with higher incomes would be asked to contribute a greater share of their incomes than required of lower income families.
 2. Since persons of all ages would benefit, persons of all ages should contribute to financing the recommendations.
 3. Revenues chosen should grow fast enough to keep up with benefit growth so that new sources of revenue will not need to be enacted over time. Rates of growth would need to be in excess of eight to nine percent per year.

The Commission report will include illustrations of the extent to which various revenue sources meet these criteria.

- C. Various combinations of revenue sources may be used that together meet these criteria, even if individual tax sources may fall short in one category.

PEPPER COMMISSION RECOMMENDATIONS ON LONG-TERM CARE

Structure of the Plan

1. Social Insurance for Home and Community-based Care

- * Severely disabled individuals of all ages are eligible for this program. This includes individuals who need hands-on or supervisory assistance with three out of five ADLs (Activities of Daily Living -- eating, transferring, toileting, dressing, bathing), or who are severely cognitively impaired.
- * Eligibility is determined by a state/local government or federally-funded non-profit assessment agency using standardized assessment criteria. This agency conducts annual audits of case managers (described below) and monitors the quality of care.
- * Case managers determine the number of hours of care and mix of services the beneficiary receives.
 - The case manager develops an individual care plan tailored to needs of the beneficiary. The availability of informal supports is included in the decision to allocate resources.
 - The case manager operates within a budget set by the federal government, and conducts periodic reassessments of the beneficiary with special consideration to be given to cost containment. The case manager budget, in conjunction with other available services, will be sufficient to provide all services needed by the patient.
- * The benefits include:
 - Home health care
 - Physical, occupational, speech and other appropriate therapy services
 - Personal care services (feeding, transferring, personal hygiene)
 - Homemaker chore services (meal preparation, laundry, housework)
 - Grocery shopping and transportation
 - Medication management
 - Adult day health and social day care
 - Respite care for caregivers
 - Cost-effective training of family members for delivery of home-based family care, and support counseling for family caregivers.

2. Nursing Home Program (NHP)

- * Individuals of all ages who are determined eligible for nursing home care by a federally certified assessment agency are covered by this program for the entire length of their stay.
- * The plan treats income and assets as follows:
 - The plan protects \$30,000 in non-housing assets for single individuals and \$60,000 for couples.
 - The plan provides a housing allowance equal to 30% of monthly income for the first year of a nursing home stay for single persons and, for married persons, as long as the spouse is alive, but at least a year.
 - The plan provides a \$100/month personal needs allowance.
 - The plan provides income protection for the spouse living in the community up to 200% of the federal poverty level for a couple.
 - Any remaining income goes toward the cost of the nursing home care.

3. Three-Month Front-end Coverage: Protection to Return Home

- * All nursing home users are covered for the first three months of care with full protection for their income and assets, except for a modest copayment.
- * Benefits include:
 - Skilled nursing care
 - Custodial care

Individual Role

1. Home and Community-based Care

- * Individuals pay 20% of the costs of care up to a maximum of the national average cost of home and community-based care.
- * The federal government subsidizes the coinsurance at least for persons with incomes below 200% of the federal poverty level.

2. Nursing Home Program

- * Individuals contribute their income toward the cost of care minus the housing and personal needs allowances.
- * Individuals contribute non-housing assets above \$30,000 for single persons and \$60,000 for married persons.

3. Three-month "Front-end" Nursing Home Care

- * Individuals pay 20% of the costs of care up to a maximum of the national average cost of nursing home care.
- * The federal government subsidizes the coinsurance at least for persons with incomes below 200% of the federal poverty level.

Financing

1. The federal government is responsible for the home and community-based care program and the three-month "front-end" nursing home care program.
2. The federal and state governments share the financial responsibility for the NHP.

Administration

1. The federal government contracts with states to administer all three components of the plan.
2. The federal government sets standards and guidelines for administration. These include the following:
 - * Standardized assessment criteria for determining eligibility for home and community-based care and nursing home care.
 - * Certification of assessment agencies.
 - * Guidelines for certifying case managers.
 - * Determination of case manager budgets.
 - * Determination of provider payment rates for home and community-based care and nursing home care.
3. State administrative functions include the following:
 - * Building on the current infrastructure for management and delivery of services, where long-term care programs already exist.
 - * Designing and implementing the system for managing and delivering services, in states without existing programs.
 - * Certifying providers.
 - * Establishing the review and appeals process.

Private Sector Role

1. Private long-term care insurance fills gaps not covered by this plan.

2. The federal government encourages the development of private long-term care insurance through clarification of the tax code. This includes:
 - * Treating, for tax purposes, the premiums paid and the benefits received as health insurance (including favorable tax treatment of life insurance benefits paid for long-term care).
 - * Enabling qualified long-term care policies to be sold in employers' cafeteria plans.
3. The federal and state governments share responsibility for standards and oversight of the private long-term care market.
 - * The federal government establishes minimum standards which private long-term care policies must meet to be eligible for the tax clarification, and establishes methods of disseminating to consumers non-biased, professional information regarding private long-term care policies.
 - * States regulate private long-term care insurance, using federal or stricter standards. The federal government will encourage states to strengthen civil penalties for misrepresenting policy standards, knowingly selling duplicative insurance or marketing unapproved policies by direct mail. In addition, states should train benefits specialists regarding private long-term care insurance and the availability of state information on that insurance.

Phase-In Schedule

Phase I

- * A maximum of 200 hours of home care per year is made available to all severely disabled persons.

Phase II

- * The three-month "front-end" nursing home care benefit is made available to all eligible nursing home users.
- * The Nursing Home Program is implemented providing income and asset protection for all eligible nursing home users.
- * Begin to improve nursing home reimbursement rates.

Phase III

- * The maximum hours of home care available per year is increased to 400.

Phase IV

- * The home care program is fully implemented, with hours of care determined by the case manager within the budget.
- * Further improve nursing home reimbursement rates.

Research Agenda for Long-Term Care

1. The federal government should move aggressively to contain costs and mitigate human suffering by funding a research and development program aimed at preventing, delaying and dealing with long-term illnesses and disabilities. This effort should include research on outcome measures and national practice guidelines in long-term care. That effort should move toward a funding level of \$1 billion annually and should do the following:
 - * Explore how to reduce the risk for certain physical and mental disorders (e.g, Alzheimer's disease, osteoporosis, breast cancer, urinary incontinence) that are associated with increased need for long-term care.
 - * Examine how to enhance the quality of long-term care including the integration of services and case management.
 - * Improve functional assessment tools to best target services to populations in need of care.
 - * Examine the special long-term care problems of subpopulations such as disadvantaged racial and ethnic minorities and the rural elderly and nonelderly disabled.
 - * Evaluate the implementation of the home and community-based care program.

Revenues for Long-Term Care

- A. Although some of the revenues necessary to support the above recommendations could come from savings achieved elsewhere in the federal budget, the Commission is committed to raising whatever additional revenues are necessary.
- B. In considering what revenue options to adopt, the Commission recommends that the choice be guided by the following three criteria:
 1. The final tax package ought to be progressive, requiring a higher contribution from those most able to bear increased tax burdens. That is, families with higher incomes would be asked to contribute a greater share of their incomes than required of lower income families.
 2. Since persons of all ages would benefit, persons of all ages should contribute to financing the recommendations.

3. Revenues chosen should grow fast enough to keep up with benefit growth so that new sources of revenue will not need to be enacted over time. Rates of growth would need to be in excess of eight to nine percent per year.

The Commission report will include illustrations of the extent to which various revenue sources meet these criteria.

- C. Various combinations of revenue sources may be used that together meet these criteria, even if individual tax sources may fall short in one category.

Phase-In Schedule and Cost of the Commission Health Care Proposal

(1990 Dollars)

Year 1

- o Initiate insurance reforms.
- o Allow all uninsured pregnant woman and children through age 6, to enroll in the public plan (fully subsidized to 185% of poverty).
- o Raise Medicaid reimbursement rates for obstetrical and pediatric care.

Total Net New Federal Cost:	\$3.4 billion
Number of Uninsured Covered:	1.3 million
% of the Uninsured Now Covered:	4%
% of Uninsured Children Under Age 6 Now Covered:	64%
% of Americans Without Health Insurance:	14%

Year 2

- o Firms with fewer than 25 employees and average payrolls below \$18,000 become eligible to receive a 40% tax credit/subsidy for the cost of health insurance that is provided. Employees of these firms with family income of less than 200 percent of poverty receive a subsidy.
- o Public plan is available to uninsured children up to age 18.
- o Improve Medicaid physician reimbursement.

Total Net New Federal Costs:	\$13.5-16.8 billion
Additional Cost from Year 1:	\$10.1-13.4 billion
Number of Uninsured Covered:	8.9-13.9 million
Projected % of the Uninsured Now Covered:	28%-44%*
% of Uninsured Children Now Covered:	58%
% of Americans Without Health Insurance:	8%-11%

Year 3

- o Firms with more than 100 employees are required to provide health insurance or contribute a portion of payroll to cover employees and dependents in the public plan.

Total Net New Federal Costs:	\$17-20.3 billion
Additional Cost from Year 2:	\$3.5 billion
Number of Uninsured Covered:	14.6-20 million
Projected % of the Uninsured Now Covered:	46%-63%*
% of Americans Without Health Insurance:	6%-8%

Year 4

- o If 80% of uninsured employees of firms with 25-100 employees (as of year 1) are not insured through their employers, along with their dependents, all employers of this size are required to provide coverage or contribute to the public plan.
- o Raise Medicaid hospital reimbursement rates.

Total Net New Federal Costs:	\$19.8 - 23.1 billion
------------------------------	-----------------------

Additional Cost from Year 3:	\$2.8 billion
Number of Uninsured Covered:	16.5 - 21.6 million
Projected % of the Uninsured Now Covered:	52%-68%*
% of Americans Without Health Insurance:	5%-7%

Year 5

- o If 80% of uninsured employees of firms with fewer than 25 employees (as of year 1) are not insured through their employers, along with their dependents, all employers of this size are required to provide coverage or contribute toward the cost of their coverage in the public plan.
- o Allow all uninsured adults into the public plan.
- o Retain subsidy to small firms with low wage employees.

Total Net New Federal Costs:	\$31.8 billion
Additional Cost from Year 4:	\$11.8 billion
Number of Uninsured Covered:	31.8 million**
% of the Uninsured Now Covered:	100%**
% of Americans Without Health Insurance:	0%

Year 6

- o Retain subsidy to small firms with low wage employees and their employees.

Total Net New Federal Costs:	\$31.8 billion
Additional Cost from Year 5:	\$0
% of the Uninsured Covered:	100%**

Year 7

- o Eliminate explicit subsidy to small firms with low wage workers and their employees.***

Total Net New Federal Costs:	\$23.4 billion
Additional Cost from Year 6:	(\$8.4 billion)
% of the Uninsured Covered:	100%**

* Depends on how many smaller firms voluntarily choose to purchase health insurance.

** If 80 percent of uninsured workers and their dependents in firms of fewer than 25 are now insured, the Secretary of Health and Human Services must submit to Congress a plan to insure any remaining uninsured. If employers with fewer than 25 do not meet this target, then the imposition of a requirement to cover all workers and their dependents or contribute to a public plan will ensure that all Americans now have health insurance.

*** Except for firms of ten employees or less at extreme financial risk.

Phase-In Schedule and Cost of Commission Long-Term Care Proposal

(1990 dollars)

Phase I

- o Home Care to 200 hours per year

Home Care	\$10.8 billion
Nursing Home Care	\$ 0.0
-----	-----
Total Costs Phase I	\$10.8

Phase II

- o Implement 3 Month Front-end Nursing Home
- o Implement Nursing Home Program
- o Begin to Improve Nursing Home Reimbursement Rates

Home Care	\$10.8
Nursing Home Care	\$14.2
-----	-----
Total Costs Phase II	\$25.0
Net Increase From Phase I	\$14.2

Phase III

- o Increase Home Care to 400 hours per year

Home Care	\$18.6
Nursing Home Care	\$14.2
-----	-----
Total Costs Phase III	\$32.8
Net Increase From Phase II	\$ 7.8

Phase IV

- o Fully Implement the Home Care Program*
- o Further Improve Nursing Home Reimbursement Rates

Home Care	\$24.0
Nursing Home Care	\$18.8
-----	-----
Total Costs Phase IV	\$42.8
Net Increase from Phase III	\$10.0

* Hours determined by the case manager within the budget.

Fully Phased-in Net New Federal Costs of the Commission Proposal

<u>SOURCE OF EXPENDITURE</u>	(Billions)
<u>Access to Health Care</u>	
Public health insurance of non-workers	\$12.4
Federal Contribution to the public plan	6.3
Tax Expenditure	6.7
Augmented Medicaid Physician and Hospital Payments	4.0
Less savings from Medicare, CHAMPUS, Medicaid	(6.0)
Sub-Total (Access to Health Care)	\$23.4
<u>Access to Long-Term Care</u>	
Home Health Care for the Severely Disabled <u>Elderly</u> (includes cost-sharing)	15.0
Home Health Care for the Severely Disabled <u>Non-Elderly</u> (includes cost-sharing)	9.0
Nursing Home Care for the Severely Disabled <u>Elderly</u>	16.8
Nursing Home Care for the Severely Disabled <u>Non-Elderly</u>	2.0
Sub-Total (Access to Long-Term Care)	\$42.8
<u>Total Net New Federal Expenditures</u>	\$66.2**

*Phase-in plan includes the cost of temporary tax credits/subsidies for certain small businesses. Those costs are not reflected in these totals, which represent the cost at full implementation, if targets are not met.

**Program costs are larger than the net new federal expenditures. Program costs would include federal spending on health and long-term care now incurred through Medicaid and state contributions as specified in the plan. The health care program is phased in over seven years and the long-term care program is phased in over four years. The costs presented above are fully phased in, in 1990 dollars.

OLDER WOMEN'S LEAGUE

NATIONAL OFFICE

STATEMENT OF LOU GLASSE,
PRESIDENT OF THE OLDER WOMEN'S LEAGUE

BEFORE THE PEPPER COMMISSION,
A HEARING ON OPTIONS IN LONG-TERM CARE

OCTOBER 5, 1989

Chairman Rockefeller, distinguished members of the Commission. Thank you for allowing the Older Women's League (OWL) the opportunity to contribute to the dialogue on how best to provide adequate long term care services to all Americans in need of this care.

As President of the Older Women's League, I have had the opportunity on numerous occasions to testify before Congress on health care issues from spousal impoverishment to adult day care to continued health insurance coverage for persons widowed, divorced, retired, or simply layed off.

OWL was the lead organization that brought continued health insurance coverage and spousal impoverishment to the attention of Congress. I think it is fair to say that we have not led you astray when it comes to knowing what the public needs and where the public sentiment lies.

I am now before you to testify on solutions to the long term care crisis facing this country. I have been advised to talk in terms of cost savings in discussing solutions, and I could do that. Some demonstration projects--San Francisco's On Lok, New York's Nursing Home Without Walls, and South Carolina's Community Long Term Care project to name a few--have shown that providing home health care services decreases the number of persons placed in nursing homes. And certainly there are opportunity costs--increased Medicaid, SSI, and other welfare benefits that caregivers need--associated with the current lack of long term care insurance coverage that would be recouped under a comprehensive plan.

But let's be honest. Any desirable long term care solution is going to cost money. What we must address today and what this Commission must determine is how much is the public willing to pay and for what services.

From the beginning of society as we know it, our long term care system has survived off the backs of our nation's midlife and older women--unpaid and unappreciated.

And this exploitive situation would continue if it weren't becoming logistically impossible because of the number of aged and young living with disabilities and diseases that would have killed them a mere five years ago, because of the increased number of seniors and decreasing number of caregivers, and because women, including midlife and older women have to be out in the workforce now because for economic survival.

In finding solutions, I must caution you to not seek short term cost savings at the expense of providing a long term solution that Americans need and will appreciate.

OWL's recommendations include:

1. Caregivers both paid and unpaid must be given the training, compensation and assistance necessary to provide quality, cost efficient care without the caregiver sacrificing her physical and financial future.

OWL recently completed the most detailed report to date on the status of paid home health care and nursing home aides. A summary of the report is provided at the end of our testimony. Here, I will simply state that the wages, benefits, and working conditions are so bad for these paid caregivers that the turnover rate for nursing aides is 70-100% each year and for home care aides, the rate is 60%, with 80-90% leaving within two years. These caregivers are earning between \$4.00 and \$4.50 an hour. We pay more to parking lot attendants who watch our cars.

The success of any long term care plan this Commission recommends will hinge on the quality of care these paid aides are able to provide. Your program will be doomed to failure from the beginning unless the plan establishes reimbursement levels higher than under our current Medicaid program. OWL recommends that this Commission look into wage pass through programs being implemented in California, New York, and most recently Michigan that tie increases in Medicaid funding directly to increased wages for workers. Rep. Walgren has a similar idea with his bill, H.R. 1649. However, we need to be careful that methods of accountability are developed for the providers to ensure that the money is going to directly to the workers and not elsewhere.

And, of course, we need to provide these paid caregivers with health insurance benefits, which I'm sure this Commission will address in its report on access to health care.

2. As for unpaid, informal caregivers, the needs of a family caregiver must not be ignored.

We are not suggesting that the federal government reimburse women for all their long hours of unpaid caregiving. That would be fair, but we realize that Congress and this Administration are not yet ready to pay women equitably for the work they do.

On the other hand, caregiving is a primary cause of poverty among older women. Studies indicate that approximately 11 percent of women quit their jobs because of caregiving responsibilities. Another 20 percent reduce their working hours. Such persons should also not have to lose their health insurance and disability coverage.

OWL recommends that health insurance pools be formed that these primary caregivers could buy into and that SSDI coverage be extended to them.

We also recommend that there be enough flexibility in a care plan for the sick and disabled developed under any new system to assist the family caregiver also.

For example, if a daughter has been providing full-time, informal care to a severely disabled mother for three years, then a care plan under a new long term care system should determine if the informal caregiver needs training, respite from caregiving, a support group, or perhaps special equipment for lifting, toileting, etc.

If during the development of a care plan, it is determined that a custodial care aide is needed, then there should be a provision to allow a family member who is working outside the home the option of becoming the paid caregiver at the same wage rate as what the unrelated custodial caregiver would have received, particularly in rural areas where paid home care workers are in scarce supply.

Many states currently pay neighbors and family members to provide home care under the 2176 Medicaid Waiver program. This same practice should continue under a long term care program. Chairman Rockefeller, you have included such a provision to pay family members in your bill, S. 785, the Medicaid Home and Community Care Options Act. It makes dollars and cents sense to allow flexibility in the program to determine how best to meet the needs of the disabled and aged.

3. We also highly recommend that our Social Security system be changed so that America's unpaid caregivers, the backbone of our health care system, not be allotted a zero in their Social Security benefits record for each year spent out of the workforce providing care for elders or children.

Either these caregivers should be given Social Security credit for their years of hard work, or at a minimum those years should not be counted in determining Social Security benefits. Under current law, women are penalized for each year spent out of the workforce by having a zero averaged in.

4. Legislation, such as the Family and Medical Leave Act, should be enacted to allow family members a temporary, unpaid leave to arrange adequate care for their children, parents, and yes, spouses.

5. In general, OWL believes that any long term care plan should be a universal, social insurance plan open to everyone of all ages and economic status who meets the coverage criteria.

6. A new Long Term Care Commission, including experts in functional assessment for the physically and cognitively impaired would be responsible for refining coverage criteria, setting reimbursement levels, and assessing the program in annual reports to Congress.

The Commission would be similar to the Prospective Payment Advisory Commission. It would be appointed by Congress to advise the Secretary of Health and Human Services on a number of technical issues.

7. Local care coordination councils would act as gatekeepers and would determine an individual's eligibility for services. Based on a comprehensive needs assessment, this council would then develop individual plans of care. The care coordination councils would be a state government agency or a private nonprofit agency that does not provide long-term care services.

8. The program should include a broad range of community and institutional services. Services including, but not limited to: SNF, ICF, skilled nursing at home, comprehensive needs assessment, care coordination, maintenance OT/PT/ST, medical social services, durable medical equipment, consumable care supplies, hospice, home health aide services, homemaker, adult day care [social and health], respite care [in-home and out-of-home], transportation [medically necessary], habilitation, mental health/psychological counseling, home adjustment equipment, speech pathology, respiratory care, personal care services, home and financial management, guardianship, meals-home delivered, minor home and vehicle modifications, protective services.

9. As for financing the program, beneficiaries would be responsible for specified copayments and deductibles. A one month deductible for both nursing home and home health care would be reasonable. For home care, after the first month, a 20% copayment could be implemented. For nursing home care, there could be a 20% copayment for days 31-100, and a 30% copayment after day 100.

High deductibles and copayments are much more severe on the married beneficiaries because the high out-of-pocket costs leave the surviving spouses impoverished.

10. There should be some protection for lower-income beneficiaries. Persons with family income below 200% of poverty should not pay any cost sharing amounts. There should be no assets test.

11. Other financing could come from: eliminating the cap on wages covered by HI portions of FICA payroll tax (perhaps eliminating the cap on the entire FICA payroll tax), reduce estate and gift tax exemption below its current \$600,000 level, create a sin tax on cigarettes and alcohol, since they contribute to poor health, and a small increase in Part B premiums.

This combination of financing methods would spread the costs among all segments of the population. Obviously, it will be up to all us, Members of Congress, the President, and grassroots organizations to make sure that everyone understands the benefits and the financing once a consensus plan develops.

We look forward to continuing to work with you and your staff in the development of your report to Congress and in implementing your recommendations. Thank you.

Representative Claude Pepper

"As I continue advocating for comprehensive long term care, I will not let my colleagues ignore the concerns of those whose daily work is caring for the elderly and disabled."

Senator John Heinz

"A key to quality long-term care is trained competent caregivers. Federal reimbursement levels must enable long-term employers to compete for the most experienced and dedicated workers."

G. Janet Tulloch, Nursing Home Resident and author of "A Home is Not a Home"

"As a nursing home resident, I know that one of the most critical aspects of quality care is having adequate numbers of well-trained nursing aides. Residents who participated in a national study on quality care agreed. Quality care prevails when residents' rights are also employees' rights."

Carolyn Wannish, Nursing Aide, Wisconsin, 13 years

"I've been working in nursing homes for over 13 years yet I only make \$5.98 per hour; new hires make \$4.50! As a full-time employee, I can barely make ends meet. And more and more employers are hiring part-timers so they don't have to pay health insurance."

Nursing Home Aides

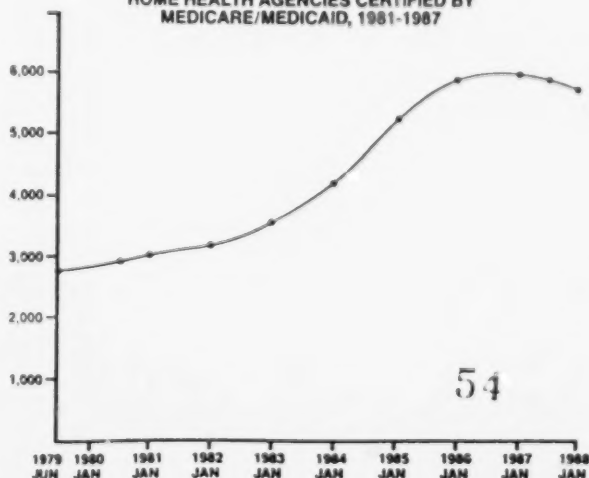
- About 1.3 million persons worked as nursing aides in the U.S. in 1986; nearly half worked in nursing homes.
- Nursing aides are virtually all women (90%) and very disproportionately minorities (38% Black and Hispanic).
- Most nursing homes (75%) are for-profit businesses; they employ two-thirds of all full-time equivalent aides working in nursing homes.
- At any given time, nursing homes average the full-time equivalent of 1 registered nurse, 1.5 licensed practical nurses, and 6.5 nursing aides for every 100 beds.
- Nursing aides are responsible for virtually all of the daily personal care of nursing home residents: feeding, bathing, toileting, dressing, moving, etc.
- The average hourly wage for aides in nursing homes is about \$4.50. In major metropolitan areas, wages vary from a low of \$3.65/hour in Houston to a high of \$8.87 in New York City. But many full-time workers and most part-time workers earn less than these averages; thousands work at minimum wage, earning a poverty level wage for themselves and their families.
- According to one national survey, from 1983 to 1988, median hourly wages for uncertified aides in nursing homes increased from \$3.35 to \$4.32; after adjusting for inflation, the before-tax increase was 2.5%/year.
- Among nursing aides working full-time in major metropolitan areas, most were working in homes that have sick leave, vacations and holidays; about half offered major medical insurance; few had a pension plan. Low-wage workers often

cannot afford the premiums and co-payments for employer health plans.

• In many parts of the country, there is a shortage of aides for nursing home work; institutions that hire temporary workers often pay temp agencies double the rates they pay their regular employees.

• Most states do not have specific training requirements and do not certify nursing aides who work in nursing homes.

HOME HEALTH AGENCIES CERTIFIED BY
MEDICARE/MEDICAID, 1981-1987



• The Department of Labor projects a need for 425,000 new nursing aides by the year 2000, with nearly all of the vacancies in nursing homes.

Home Health Aides

• At least 300,000 persons work as home health aides in the United States, but little reliable national data about them exists.

• Like nursing aides, home health aides are nearly all women and are disproportionately Black and Hispanic; most are middle-aged or older.

• The majority of home health aides are single (widowed, divorced or never married) and are the primary economic support for their families.

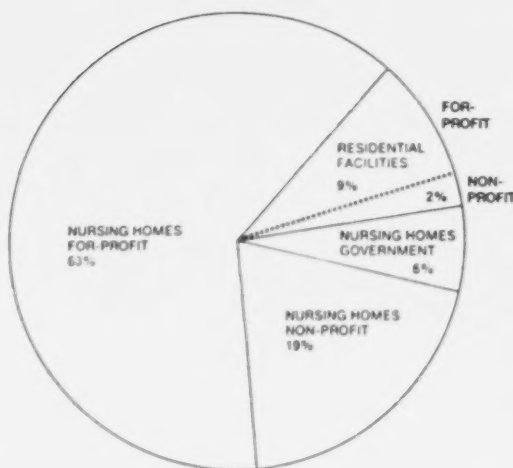
• Average hourly wages for home health aides are about \$4.25, but many work for minimum wage.

• Home health aides earn less than their counterparts in nursing homes, are more likely to work part-time, and are less likely to have any benefits.

• Home health aides are usually not paid for the time required to travel from one patient to another on the same day.

• The majority of home health aides leave their jobs within two years.

BEDS IN NURSING AND RELATED CARE HOMES



Source: National Center for Health Statistics, Advance Data No. 147

Odessa Powell,
Housekeeper, New York City,
11 years (President, Local
389 AFSCME)

"I am proud of my job of caring for the elderly and sick and disabled, but it's hard work and requires a lot of patience and the wages are much too low for the kind of care we're expected to give. If you expect quality care, you must be willing to pay for it."

Elma Holder, Executive
Director, National Citizens
Coalition for Nursing Home
Reform

"The nursing aide is the most valuable yet under-rated caregiver in our health care system. NCCNHR urges the public to join us in supporting efforts to improve their training opportunities and increase wages and benefits. They deserve praise and admiration for their work."

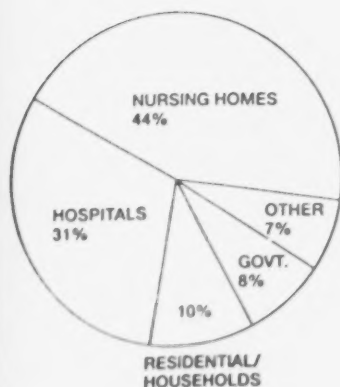
Myrtle King, Berkeley, CA
Caregiver Contributor to OWL's
Women Take Care

"My husband had Alzheimer's Disease. As his condition worsened, I became his mother, nurse, and conservator. He required around the clock care. Outside help would have been a god-send—to have a break from the everyday demands, to be free to breathe fresh air. But there were no caregivers to hire—not even for a day!"

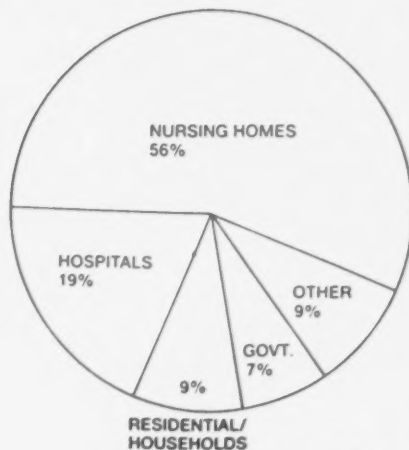
Maggie Blanche, AFSCME
Retiree Chapter 13, Pennsylvania
"My aunt has to continually get used to new people and that's so hard for her. Especially when you consider that the aides bathe her and take care of her personal needs. Once she gets used to someone, the person leaves and she has to get used to someone else."

NURSING AIDES: OUT OF HOSPITALS, INTO NURSING HOMES

1986



2000



1,205,000 AIDES

1,629,000 AIDES



Act!
LEWIS N. DODAK
SPEAKER OF THE HOUSE

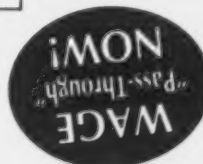
SEIU
419 S. WASHINGTON
LANSING, MI 48933-9839

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INCREASE BY **\$1,248**
THIS YEAR . . .



open here



. . . But you must act before Lansing does!

RN's, LPN's, and Nurses Aides stand to gain **immediate wage increases of up to 60¢ per hour** if the new SEIU-initiated proposal is passed by the legislature.

On Monday, May 1, 1989 the House Social Services Appropriations sub-committee approved a "wage pass-through" proposal in the most recent Medicaid budget. If eventually passed by the House and Senate and approved by the Governor, 60¢ per hour could mean \$1,248 extra in your paycheck if you are working full-time (2,080 hours x 60¢).

SEIU, Michigan's largest health care workers union, has led this fight for this **wage pass-through**. If enacted, it would be the single **largest legislative increase and the first-ever, for nursing home workers**. The Appropriations Committee estimates the total state/federal cost at **\$24 million**.

If and when this increase is implemented really depends on **you**. If the Speaker of the House hears your voices – the voices of nursing home workers – we stand a very good chance of winning real wage increases. But you must **ACT NOW!**

MAIL THE ATTACHED CARD, TODAY! Don't delay, we need to deliver our message. The House could act as early as May 15.

Paul Policicchio, President
SEIU Local 79

P.S. This increase for "direct patient care" personnel will help **all** nursing home workers by "pulling" service and maintenance, dietary, and other classifications up with them. Negotiating a strong contract will be even more important for these workers.

DEAR SPEAKER DODAK:

I work in a nursing home and I am tired of being one of the lowest-paid, least appreciated, and over-worked of all workers in our state.

***Average nursing home wages are \$4.12 in Michigan.** A 1985 Bureau of Labor Statistics Survey of 21 U.S. cities ranked Detroit 18, third from the bottom. According to SEIU, that means we only make **85% of the Federal poverty level** for a family of three.

***Staff turnover** in some homes is **150 - 200% per year**. Constant turnover means patient care suffers.

We need your support for a "wage pass-through" as used in other states. A fully-funded "wage pass-through" will mean a **60¢ an hour increase**, or \$1,248 if full-time. Your support for a "wage pass-through" means **higher quality care** and a **fairer wage** for 30,000 nursing home workers.

Name _____ Phone _____ Sincerely, _____

Address _____ City/Zip _____

Nursing Home _____



Medicaid raise is relief for nurses

By Bradley Flory

Staff Writer

In a move applauded by management and labor, the state is putting up money for pay raises to nurses who work at nursing homes throughout Michigan.

Raises of up to 50 cents an hour would be financed by a first-ever "wage pass-through" provision in the 1989-90 budget for the Michigan Department of Social Services.

The budget, made final last week when signed by Gov. James J. Blanchard, sets aside money that can only be used for raises to nurses in Medicaid-certified nursing homes.

At least eight Jackson-area nursing homes or long-term care facilities are affected, according to the Service Employees International Union (SEIU), a union for nursing home workers that pushed for the raises.

Statewide, 30,000 registered nurses, licensed practical nurses and nursing aides are in line for raises, the union says.

The SEIU says the legislation will help improve "poverty wages" for nursing home nurses.

"Nurse aides average slightly more than \$4 an hour now, which means that they only make 85 percent of the federal poverty level for a family of three," said Paul Pollicchio, president of SEIU Local 79.

Pollicchio said low wages and high turnover lead to inadequate employee training and a resulting lack of quality care for nursing home patients.

Operators of nursing-care facilities near Jackson say the legislation will help make nursing home pay a little more competitive with hospitals.

"Any relief that can be given people in this profession will be welcome," said Lloyd G. Ganton, president of Ganton Retirement Centers Inc. The company operates six facilities, although not all are traditional nursing homes, and employs 15 to 20 nurses, Ganton said.

"It's got to be an improvement," said Donald L. Hampstead, director of the Jackson County Medical Care Facility.

Hampstead and Ganton both said nursing homes and care facilities cannot compete financially with hospitals in paying nurses.

"Our Medicaid rate is so low that they don't cover our costs," said Ganton. "As a result, we can't pay our people what they deserve. We're just caught in a real tough position."

It is not yet clear how nursing-care facilities will get the money from the states or when nurses will get it in their paychecks.

Staff writer Dee Cavins and wire



MEDICAL ASSISTANCE PROGRAM BULLETIN

EFFECTIVE: Rate Setting Periods Beginning on or After
October 1, 1989.

SUBJECT: Elimination of Grandfather Provisions for Plant
Cost Reimbursement and Change in Inflationary
Adjustment for Fiscal Year 1989-90.

To comply with the requirements of Enrolled House Bill 4054 of 1989, the legislatively mandated inflation factor for Fiscal Year 1990 is an average of 4% for facility fiscal years beginning on or after October 1, 1989, and grandfather provisions that allow Class I and II facilities to use previous methods of plant cost reimbursement are eliminated.

For facilities affected by elimination of grandfather provision, the plant cost component will now be determined using the Revised Plant Cost Component methodology issued in Bulletin 5370-85-02, effective April 1, 1985. As a result of this change, some providers will no longer have the option of receiving a higher plant cost component as determined by the methodology in effect prior to April 1, 1985.

The 4% limit is intended to confine inflation adjustments for Variable Cost increases. Of this 4%, at least 2% will be used for a wage and benefits pass-through for direct patient care staff. The rate increase for enhanced wages and benefits will be provided to facilities which make application for it. This 2% rate increase will fund the Medicaid program share of wage and benefits increases to a maximum of \$.50 per hour per direct patient care employee. The remaining 2% will be used as a prospective inflationary adjustment within the rate setting process.

AFFECTED PROGRAM(S): Medicaid

PROVIDER DISTRIBUTION: Long Term Care Manual Holders

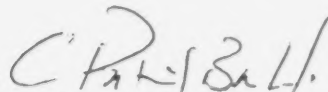
ISSUED: September 1, 1989

Application for the wage pass-through is intended to coincide with each individual facility rate year. If there are special circumstances that require midyear reconsideration for increasing or decreasing the wage pass-through, the facility may submit a revised application for wage pass-through. The Medical Services Administration will make a determination of whether the change is significant enough to warrant an interim rate change or whether the change will be recognized in the settlement process.

INQUIRIES

Inquiries regarding this bulletin should be directed to: Medicaid Information Division, Medical Services Administration, P.O. Box 30037, Lansing, Michigan 48909; or phone toll-free from within the State of Michigan 1-800-292-2550. Providers located outside Michigan may call (517) 335-5150.

Approved:


Director



Kevin L. Seitz, Director
Medical Services Administration

Attachment

MICHIGAN DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES ADMINISTRATION

DIRECT PATIENT CARE WAGE PASS-THROUGH REQUEST

(Please type or print in ink)

FACILITY NAME: _____

COUNTY: _____ CITY: _____

PROVIDER ID#: _____ PROVIDER TYPE: _____

FISCAL YEAR: from _____ to _____

TYPE & NUMBER OF DIRECT PATIENT CARE STAFF: (current FTEs)

TYPE	NUMBER
<u>RNs</u>	_____
<u>LPNs</u>	_____
<u>Nurse Aides</u>	_____

PROPOSED CHANGES IN NUMBER OF DIRECT PATIENT CARE STAFF:

TYPE	NUMBER
<u>RNs</u>	_____
<u>LPNs</u>	_____
<u>Nurse Aides</u>	_____

CURRENT AVERAGE WAGE AND PROPOSED AVERAGE CHANGE:

TYPE	CURRENT AVG WAGE/HR	PROPOSED AVG WAGE/HR
<u>RNS</u>	_____	_____
<u>LPNs</u>	_____	_____
<u>Nurse Aides</u>	_____	_____

NUMBER OF PATIENT DAYS--ANNUALLY: _____
TOTAL DAYS MEDICAID DAYS

EXPENSE CLASSIFICATION FROM WORKSHEET #1 OF THE COST REPORT:

TYPE	SALARIES	BENEFITS	TAXES
<u>RNS</u>	_____	_____	_____
<u>LPNs</u>	_____	_____	_____
<u>Nurse Aides</u>	_____	_____	_____

This certifies that, to the best of my knowledge and belief, the above information is true and accurate. I understand that if pass-through payments exceed actual expenditures by more than 5% a penalty factor will be applied.

DATE _____

PROVIDER SIGNATURE

NAME (TYPED) _____

APPENDIX D

FEDERAL WAGE PASS THROUGH BILL

I

101ST CONGRESS
1ST SESSION

H. R. 1649

To amend title XIX of the Social Security Act to require nursing facilities participating in the medicaid program to pay, on a phased-in basis, nursing personnel at a rate at least equal to the mean rate paid nursing personnel employed outside nursing facilities.

IN THE HOUSE OF REPRESENTATIVES

MARCH 23, 1989

Mr. WALGREN introduced the following bill; which was referred to the Committee on Energy and Commerce

A BILL

To amend title XIX of the Social Security Act to require nursing facilities participating in the medicaid program to pay, on a phased-in basis, nursing personnel at a rate at least equal to the mean rate paid nursing personnel employed outside nursing facilities.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 SECTION 1. MINIMUM WAGE RATE FOR NURSING PERSONNEL

4 IN NURSING FACILITIES.

5 (a) MINIMUM WAGE RATE REQUIREMENTS.—Section
6 1902(a)(13) of the Social Security Act (42 U.S.C.
7 1396a(a)(13)) is amended—

1 (1) by striking "and" at the end of subparagraph
2 (D);

3 (2) by inserting "and" at the end of subparagraph
4 (E); and

5 (3) by adding at the end the following new sub-
6 paragraph:

7 "(F)(i) in making payment for nursing facility
8 services under the plan, for payment of the costs
9 (attributable to individuals receiving medical as-
10 sistance under the State plan) of wages and bene-
11 fits of the facility's nursing personnel (including
12 nurses' aides) who provide or supervise direct care
13 of residents at a rate that is at least equal to the
14 minimum rate of wages and benefits established
15 under subsection (s)(1) for nursing personnel in a
16 locality in the State;

17 "(ii) for recovery by the State (through offset
18 or otherwise) from a nursing facility of such
19 amounts as are paid to the facility pursuant to
20 clause (i) but are not expended by the facility for
21 wages and benefits of nursing personnel described
22 in such clause; and

23 "(iii) that the State shall—

24 "(I) for the period consisting of the
25 4 calendar quarters that ends at least

1 180 days before this subparagraph is ef-
2 fective in the State, conduct a survey to
3 determine, through a statistically repre-
4 sentative sample, the mean rate of
5 wages and benefits paid in each locality
6 in the State to nursing personnel (in-
7 cluding nurses' aides) who provide, in
8 nursing facilities, nursing services de-
9 scribed in clause (i) to individuals re-
10 ceiving medical assistance under the
11 State plan,

12 “(II) for periods consisting of the 4
13 calendar quarters that end at least 180
14 days before each period described in
15 subsection (s)(1), conduct a survey to
16 determine, through a statistically repre-
17 sentative sample, the mean rate of
18 wages and benefits paid in each locality
19 in the State to nursing personnel (in-
20 cluding nurses' aides) who provide, out-
21 side nursing facilities, nursing services
22 comparable to those described in clause
23 (i),

24 “(III) report to each nursing facili-
25 ty in a locality in the State on the mean

1 rates of wages and benefits determined
 2 under subclauses (I) and (II) for that lo-
 3 cality, and

4 “(IV) report to the Secretary on
 5 the mean rates of wages and benefits
 6 determined under subclauses (I) and (II)
 7 for each locality in the State;”.

8 (b) COMPUTATION OF MINIMUM WAGE RATE.—Sec-
 9 tion 1902 of such Act is further amended by inserting after
 10 subsection (r) the following new subsection:

11 “(s)(1) Except as provided in paragraph (2), for the pur-
 12 poses of subparagraph (F) of subsection (a)(13), the minimum
 13 rate of wages and benefits for nursing personnel in a locality
 14 in the State—

15 “(A) for the first 4 calendar quarters in which
 16 such subparagraph is effective in the State, is 66.5
 17 percent of the base rate plus 33.5 percent of the ad-
 18 justed rate,

19 “(B) for the next 4 calendar quarters in which
 20 such subparagraph is effective in the State, is 66.5
 21 percent of the base rate plus 33.5 percent of the ad-
 22 justed rate,

23 “(C) for the next 4 calendar quarters in which
 24 such subparagraph is effective in the State, is 33.5

1 percent of the base rate plus 66.5 percent of the ad-
2 justed rate,

3 “(D) for the next 4 calendar quarters in which
4 such subparagraph is effective in the State, is 33.5
5 percent of the base rate plus 66.5 percent of the ad-
6 justed rate, and

7 “(E) for each succeeding period of 4 calendar
8 quarters in which such subparagraph is effective in the
9 State, is 100 percent of the adjusted rate.

10 “(2) If during any period described in paragraph (1), the
11 base rate is greater than the adjusted rate, for the purposes of
12 subparagraph (F) of subsection (a)(13), the minimum rate is
13 the base rate.

14 “(3) As used in this subsection—

15 “(A) the term ‘base rate’ means the rate deter-
16 mined for the locality under subsection (a)(13)(F)(iii)(I),
17 and

18 “(B) the term ‘adjusted rate’ means the rate de-
19 termined for the locality for the appropriate period
20 under subsection (a)(13)(F)(iii)(II).”.

21 (c) **TRANSITION.**—For the purposes of the amendment
22 made by section 1(3), for periods ending before October 1,
23 1990, any reference to “nursing facility services” shall be
24 deemed a reference to “skilled nursing facility services” and
25 “intermediate care facility services”

1 SEC. 2. INCORPORATING REQUIREMENTS INTO STATE PLAN.

2 (a) EFFECTIVE DATE.—The amendment made by sec-
3 tion 1(3) applies to payments under title XIX of the Social
4 Security Act for calendar quarters beginning with the first
5 calendar quarter that begins more than 180 days after the
6 date of the enactment of this Act, without regard to whether
7 regulations to implement such amendment are promulgated
8 by such date.

9 (b) STATE PLAN AMENDMENTS.—If an amendment to
10 a State plan for medical assistance under title XIX of the
11 Social Security Act is necessary for compliance with the re-
12 quirements of section 1902(a)(13)(F) of such Act (as added by
13 section 1(3) of this Act), then the State shall submit such
14 amendment to the Secretary of Health and Human Services
15 not later than 90 days after the date of the enactment of this
16 Act. The Secretary shall, not later than 180 days after the
17 date of the enactment of this Act, review each such plan
18 amendment for compliance with such requirements and by
19 such date shall approve or disapprove each such amendment.
20 If the Secretary disapproves such amendment, the State shall
21 immediately submit a revised amendment which meets such
22 requirements. The absence of approval of such a plan amend-
23 ment does not relieve the State or any nursing facility of any
24 obligation or requirement under title XIX of the Social
25 Security Act.

APPENDIX E

OWL MEDIA CAMPAIGN

St. Louis Post-Dispatch 12/17/89

Who Cares About Long-Term Care Workers?

By Lou Glasse

What kind of care are our family members likely to get when they become old or disabled? Can we count on the availability of decent, affordable care for our families and ourselves? Are the people who provide that care properly trained, experienced and paid fairly for their work?

Caregiving is critically important to an aging society, and recently, the Older Women's League has become the pre-eminent authority on unpaid caregiving. Our experts have documented what many of our members already knew: that the burdens and stress involved in caring for chronically ill loved ones can jeopardize the physical and mental health, savings and earning power of the caregiver. We have become a strong voice urging employers to make leave available to workers who must care for a gravely ill relative, and urging policy-makers to support respite care to help unpaid caregivers.

When the Older Women's League launched a research and public education project early this year to assess the status of paid caregivers, we suspected that we would find a problem. What we found was even more serious than we anticipated: The work of long-term care workers, like paid caregivers, is grossly undervalued.

This is a serious concern for most Americans, and the evidence is alarming. Many of the people who are paid to provide custodial care to America's chronically ill are in dire straits themselves. The workers who make beds, give baths, see that medicine is taken and

otherwise care for the elderly and disabled are often struggling themselves just to survive.

The United States has about 1.5 million long-term care workers — people who work as nursing aides in nursing homes or as home health-care workers. Nearly all are women, usually middle-aged, and many are African American. They receive little or no training as they care for a rapidly growing population that is increasingly needy. Typically, long-term care workers are paid at or near mini-

and older women are being forced to take low-wage, dead-end jobs at precisely the time in their lives when they should be planning and saving to protect themselves in their own old age.

Many of this country's midlife and older women find themselves on both sides of the health-care equation; first, as poorly paid long-term care workers and unpaid caregivers; and subsequently, as the impoverished recipients of nursing-home care.

It is time to face the hard facts. Every

American family is likely to face chronic illness at some point. If we want quality care to be available to our loved ones, we must search now for a way to pay for it.

The current shortages of long-term care workers in the Northeast and the West portend what the entire nation is likely to face in coming years. Unless pay scales and work incentives improve, the problem can only get worse. Congress can help.

Increasing the minimum wage, requiring employers to provide health insurance and pensions and supporting pay equity will help end the exploitation of long-term care workers.

This situation cannot continue unchecked. America is on the brink of a full-blown crisis in caregiving for the chronically ill. An exploited, overburdened workforce is caring for the frail, the sick and the elderly. We must find a way to compensate them fairly for the work that they do, or the consequences will be grave — for our parents, our spouses and ourselves.

Lou Glasse is the national president of the Older Women's League.



mum wage; only about half have employer-sponsored major medical insurance and few have pensions.

With poor pay, few benefits or opportunities for promotion, little training and difficult working conditions, the turnover among long-term care workers is high. Tales of interviewing for jobs and beginning work on the same day are commonplace. When aides are inexperienced, the quality of care for the frail elderly suffers. The exploitation of long-term care workers endangers the patients for whom they care.

Our parents, or spouses and our siblings are being cared for at the end of their lives by overworked, underpaid, undertrained workers. And middle-aged

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Caring for Elderly: Undervalued Work

By Lou Glasse

WHAT kind of care are family members likely to get when they become old or disabled? Can the availability of decent, affordable care be counted on? Are the people who provide that care experienced, properly trained, and paid fairly for their work?

Care-giving is a critically important issue to an aging society, and in recent years the Older Women's League has become the preeminent authority on unpaid care-giving. Our experts have documented what many of our members already knew: that the burdens and stress involved in caring for chronically ill loved ones can jeopardize the physical and mental health, savings and earning power of the care-giver. We have become a strong voice urging employers to make leave available to workers who must care for a relative, and urging policymakers to support respite care to help unpaid care-givers.

When the Older Women's League launched a research and public-education project early this year to assess the status of paid care-givers, we suspected that we would find a problem. What we found was even more serious than we anticipated: The work of long-term care workers, like paid care-givers, is grossly undervalued.

This is a serious concern for most Americans, and the evidence is alarming. Many of the people who are paid to provide custodial care to America's chronically ill are in dire straits themselves. The workers who make beds, give baths, see that medicine is taken, and otherwise care for the elderly and disabled are often struggling themselves just to survive.

The US has approximately 1.5 million long-term care workers — people who work as nursing aides in nursing homes or as home health-care workers. Nearly all are women, usually middle-aged, and a disproportionate number are African-American. They receive little or no training as they care for a rapidly growing and increasingly needy population. Typically, long-term care workers are paid at or near minimum wage; only about half have employer-sponsored major medical insurance and few have pensions.

With poor pay, few benefits or opportunities for promotion, little training, and difficult working conditions, the turnover among long-term care workers is high. Tales of interviewing for jobs and beginning work on the same day are commonplace.

When aides are inexperienced, the quality of care for the frail elderly suffers. The exploitation of long-term care workers endangers the patients for whom they care.

Many parents, spouses, and siblings are being cared for at the end of their lives by overworked, underpaid, undertrained workers. And middle-aged and older women are being forced to take low-wage, dead-end jobs at precisely the time in their lives when they should be planning and saving for their own future.

America's midlife and older women find themselves on both sides of the health-care equation: first, as poorly paid long-term care workers and unpaid care-givers; and subsequently as the impoverished recipients of nursing-home care. The majority of long-term care workers are midlife women who are the sole support for their families. They are paid so little that they are likely to end up in poverty themselves.

It is time to face the hard facts. Most American families are likely to face chronic illness at some point. If quality care is to be available to loved ones, the search for a way to pay for it should begin now.

The current shortages of long-term care workers in the Northeast and the West portend what the entire nation is likely to face in coming years. Unless pay scales and work incentives improve, the problem can only get worse. Congress can help. Increasing the minimum wage, requiring employers to provide health insurance and pensions, and supporting pay equity will help end the exploitation of long-term care workers.

This situation cannot continue unchecked. America is on the brink of a full-blown crisis in care-giving for the chronically ill. An exploited, overburdened work force is caring for the frail, the sick, and the elderly. We must find a way to compensate them fairly for the work they do.

■ Ms. Glasse is the national president of the Older Women's League.

Giving a hoot about caregivers

OWL cares for those who care for others

By Judi Hunt

Americans who end up raising children and caring for elderly relatives at the same time are bone-weary from being unpaid caregivers.

These folks, says Jayne Mason Burnbaugh, need some time off. Getting it, however, is virtually impossible with so little respite care available, she says.

Burnbaugh is acting president of the Seattle chapter of the Older Women's League (OWL), an advocacy group that has taken on the task of helping women, mostly between the ages of 45 and 82, who care for elderly relatives without compensation or benefits.

In Washington state, unpaid caregivers account for 78 percent of all people who work with the elderly, including professionals, says Burnbaugh.

Time off, however, is just one of the social issues that OWL is tackling as the organization approaches its 10th year.

OWL BEGAN in 1980 as a voice for older women whenever public policy is made, Burnbaugh says. The non-profit organization is working for social and economic equity for older women, and also to improve their image and status.

Among OWL's major concerns is what to do about federal cuts that directly affect women, families and senior citizens. Those cuts are the major topic of the Seattle chapter's next meeting, Sept. 9 at OWL's council house, 1501 17th Ave. The meeting is open to prospective members of both sexes.

"Fifty to 80 years ago, women raised their kids and then maybe had a few years of taking care of elderly relatives before the older folks died," she says.

"Now, with people living longer, caring for an elderly person can extend to 18 or more years."

That leaves caregivers desperately tired and overextended, in need of a few hours for themselves and often no way to get it, says Burnbaugh, 62.

"When respite care is available, such as adult day care or someone to come in for three or four hours, it usually is in metropolitan centers. There's not much help in rural areas, where the bulk of unpaid caregiving occurs."

FINDING WAYS to relieve those who nurse the elderly is such a priority of OWL that the organization has written a bill of rights for paid caregivers that focuses on the plight of these people, most of whom are women, says Joan Kuriansky, executive director of the national group, with headquarters in Washington, D.C.

"These women, many of them employed in nursing homes, often have no benefits, such as pensions, and are given very little training," Kuriansky says. "They are predominantly middle-aged women of color who work for minimum wages."

The problems of family members who act as unpaid nurses aren't forgotten by OWL, either, Kuriansky says.

"We're working toward a national family medical policy that will cover the needs of spouses, not just adult children, who are caregivers."

During National Caregivers Week, the third week of November, OWL groups will focus on those who serve the elderly. Plans are to have



Virginia Redeker helps Walter Hilary, 86, on his walk near his home in West Seattle. An Older Women's League activist, Redeker says "I want things to be better for my daughter when she gets to be my age."

members "adopt" a caregiver or ask legislators to substitute as caregivers for a day.

Some of the nation's 120 OWL chapters — Seattle is one of the largest with 200 members — will honor specific caregivers in their communities, Kuriansky says.

Other OWL priorities include working to protect present Social Security benefits and

improving the system so it represents women more fairly and adequately, she says.

Of particular interest to Seattle area members like Burnbaugh and Virginia Redeker, both ex-wives of military men, are OWL's efforts to help impoverished military wives who have been

See OWL, Page C4

OWL: It helps care for the caregivers

From Page C1

left without medical insurance. Burmbaugh and Redeker had no medical coverage for long periods following their divorces.

Then, with the passage of the Former Spouses Protection Act in 1984 by Congress, long-term military ex-spouses were given military medical coverage and privileges to use the base commissary and post exchange.

Another bill, the Group Health Continuation Act, was passed in 1986. It allows dependents who had employer group health benefits the right to continue that coverage for up to three years by paying their own premiums.

The military health coverage is going to make a huge difference in Redeker's life when she undergoes brain surgery soon at Madigan Medical Center in Tacoma, she says. The cost of surgery will be covered.

Redeker, 64 and currently a paid caregiver, is working for legislation that would allow present and former military spouses to share in their deceased spouses' pensions.

"All we've got now is supplemental Social Security, and that doesn't allow us any kind of decent life. We've fallen through the cracks of the social system," she says.

OWL's goals brought Redeker into the organization, even though she also is a member of the American Association of Retired Persons.

"I want things to be better for my daughter when she gets to be my age," she says.

Ellen Christensen, 63, joined OWL because she was worried about Social Security rules that don't cover the years women stay home raising children.

"That 15 years I spent at home with my youngsters was 15 years that I didn't pay into Social Security. Now women like me are in a pickle," she says.

Christensen wants women to get Social Security credit for the periods they stay at home, by allowing the husband's earnings to be considered shared family income.

She also hopes OWL will improve the image of older women.

"I foolishly thought that since I was a college graduate with job experience that I wouldn't have trouble getting work at 43," Christensen says. "I was wrong."

OWL's Seattle phone number is 461-3620.

Chronic Care Crisis

The needs of chronic care workers, the home health-care and nursing home aides who care for America's fast-growing frail elderly population, will be the focus of an 18-month research and public education project by the Older Women's League (OWL).

The campaign will include a paper on public policy issues affecting chronic care workers, formation of a coalition of women's and aging groups and unions to address the ongoing needs of chronic care workers, and development of a research agenda to identify information gaps related to this segment of the workforce. The project is being financed in part by a grant from the Retirement Research Foundation.

One and a half million Americans who work as nursing aides at nursing homes and as home health-care workers are almost entirely women, a disproportionate number are minorities, and many are middle-age or older workers who may soon face old age themselves. If conditions do not improve, the shortage of chronic care workers will worsen in coming years.

For more information, contact Lisa Lederer, Older Women's League, 730 Eleventh Street, NW, Suite 300, Washington, DC 20001; 202-371-1999.

Puppets Teach Children About Arthritis

Ronald McDonald Children's Charities and The Coca-Cola Foundation have awarded matching grants totaling \$317,500 to the Arthritis Foundation to fund a nationwide puppet program to help children understand and accept people with arthritis or other disabilities.

The Kids on the Block—Arthritis Pro-

gram uses nearly life-size hand and rod puppets to explain to third- and fourth-grade students how someone with arthritis is the same as or different from other people. Puppet characters demonstrate how to be a friend to someone with arthritis.

The two grants will enable the Arthritis Foundation to purchase puppets and train 250 volunteers for 72 sites. The volunteers will present the program in schools and communities nationwide. Volunteers perform a script in which a puppet with arthritis explains to one without arthritis what it is like to have a chronic disease. Puppet characters also answer questions from children in the audience.

One of the puppet characters, named Leslie Rosenbaum, is 10 years old and has juvenile rheumatoid arthritis. Another, Pete Whetstone, is a retired mail carrier with osteoarthritis. He is a teacher's aide in Leslie's school. Pete's character is likely to be familiar to children who have a grandparent with arthritis.

For more information, contact Dennis Bowman, Arthritis Foundation, 1314 Spring Street, NW, Atlanta, GA 30309; 404-872-7100.

US Unprepared for Next Century

America is ill-prepared to meet the challenges of an aging society in the 21st century, according to the Gerontological Society of America, which notes that not enough has been done to gather information about a segment that in 35 years will account for a fifth of the population.

In its paper on "The Aging Society and Opportunities for the New Administration," the Society called on the administration to improve its data base before

issues become critical problems. It also called for a more coordinated and efficient dissemination of federal data by the Office of the Commissioner on Aging.

The paper notes that unless trends are documented accurately, it will be difficult to devise effective policy options. The paper cites examples such as the impact of earlier retirement and longevity on Social Security and the impact of health-care programs of an expanding disabled older population and fewer family caregivers.

The Gerontological Society states that the federal government's decentralized data collection effort related to aging issues is both inadequate and disoriented. It lacks the data it needs and at times cannot use the data it has. What needs to be done is to identify and fill critical data needs and synthesize and disseminate data collected by various agencies.

For more information, contact Linda Krogh Harootyan, The Gerontological Society of America, 1275 K Street, NW, Suite 350, Washington, DC 20005-4006; 202-842-1275.

Gerontologist of Year Named

Gordon Streib, PhD, graduate research professor in the Department of Sociology at the University of Florida, Gainesville, was named Gerontologist of the Year during the Annual Aging in Florida conference in Orlando.

Streib, a sociologist and pioneer Florida gerontologist, has been responsible for increasing research efforts and government programs in the areas of specialized living environments for the elderly and caregiving techniques and methods.

SOCIAL STUDIES



Suzanne Ruta asks
who's going to take care
of our parents.

My large, close-knit family is scattered along the eastern seaboard. It makes for strenuous commuting, and our family tree is also a phone tree. A lonely cousin in New York tries to reach my Aunt Nora on the phone and gets a busy signal four hours running. She calls my mother, but gets no answer because my mother's with her ailing sister, Lucie. So she phones my Aunt Ruth in Jersey. Ruth hesitates and phones my mother in Connecticut. My mother calls me with the alarming news: Nora can't be reached. I offer to phone the operator, who tells me that Nora's line is out of order. I call my mother and then Ruth to let them know what's what. Ruth is glum about her sister-in-law, who's sinking fast in a Brooklyn nursing home, and she tells me that as soon as she's free (she means after the funeral) she's going up to Connecticut to spend some time with Lucie. I can tell she feels guilty she's not there already, but what can she do, she's needed in Brooklyn. Even in a big family like ours, there's not enough love to go around.

And, of course, families are getting smaller. My friend Nicole is the only child of an only child, and she's been nursing her mother through a series of strokes for a year, battling doctors with

no bedside manners, throwing away pills with horrendous side effects, juggling the schedules of the two women—one from Guyana and the other from Trinidad—who stay with her mother round the clock, and continuously worrying that her mother's small savings won't cover the women's salaries. Some days she phones me to report a brilliantly funny line her mother came out with, a flash of her former wit from the enveloping fog, and other days I call her and she can barely talk for grim exhaustion.

What shall we do with you when you get that way, my daughter asked the last time I told her how things stood with Nicole's mother. I remembered a friend who told us how, in the South during the Depression, he obeyed his father's orders and brought him his gun in the hospital so he could make a quick end before the family's savings were gone. "Shoot me," I said, and caught the glint in my activist daughter's eye. She loves a dramatic solution.

But there must be some social or political measure that would help families face old age without feeling so pulled apart, and that would aid the women who hold them together—because those who take care of the elderly are mostly women, often daughters or other relatives. Work that so many people do for nothing is bound to be poorly paid when it's done for wages. According to Laura Loeb of the Older Women's League, the national average for home-care workers and nursing-home aides is between \$4.25 and \$4.50 an hour. "We pay parking-lot attendants more to look after our cars," she told me. And many of the elderly are scarcely better off—thirteen weeks in a nursing home is enough to use up the savings of half the people who enter them. Only when your assets are reduced to an average of two thousand dollars or less will Medicaid begin to pick up the bill. (Medicare coverage is limited to short-term medical emergencies.) This means that once you've gone into a nursing home you're not likely to come out again.

No country rewards youthful ambition and intelligence as promptly as ours, and none in the developed

world punishes failure, disease, and decline so severely. "The U.S. has always been behind the rest of the industrialized world in social legislation. Germany had social security fifty-three years before we did," says Eleanor Litwak, who runs the Retirees' Education Program for District Council 37 of the American Federation of State, County, and Municipal Employees. While women in France can take unpaid leave to care for parents, and Sweden is considering proposals to pay monthly stipends to women who must quit work altogether, we can't take time off without fear of losing our jobs. This year, Congress may pass a family medical leave act, long overdue, but Litwak is working on something much bigger: a national program that would provide insurance to everyone, regardless of age or income, for long-term care. Financed from payroll taxes, it would also fund support services that allow the elderly and the handicapped to live independently.

It sounds sensible, but with Social Security already putting a regressive tax burden on working people and Medicare costs rising all the time, is the country ready for another major entitlement program? A two-year study by the congressional Bipartisan Commission on Comprehensive Health Care, which was released to much fanfare last March, also called for universal health insurance and expanded long-term care. But the commission, under pressure from the Bush Administration not to recommend a tax increase, would not say who was going to pay for the \$86.2 billion-a-year program.

Nevertheless, the long-term care campaign has a lot of backers, and the worst thing one could accuse them of is a lack of political realism. But "realism" in this context is even more depressing. The Reagan years spawned a series of hardheaded think-tank books on the problems of our aging society. Even moralists and philosophers succumbed to fashionable cost-benefit analyses and zero-sum games to prove that we can't afford to care for the elderly in a humane way if they're going to insist on living so long in such large numbers. Some pundits, like those in a group

called Americans for Generational Equity, suggest that the elderly are hogging resources better spent on the young, who can help us compete economically with Japan (itself an aging society, but never mind that).

The best political thinking is done on the front lines, and, where the ailing elderly are concerned, that means among middle-aged and elderly women. Sitting in an emergency room for eight hours with your eighty-four-year-old mother is a radicalizing experience, as my friend Nicole has been telling me.

The way we fail to care for our elderly is part of a larger crisis: young mothers who use the emergency room as the family pediatrician, pregnant women who see a doctor for the first time when they give birth, long-running strikes in which the main issue is who pays for the employees' health benefits. Big problems require big solutions, and that's why it was refreshing to talk to Charlotte Flynn of the Austin, Texas, Gray Panthers. The Panthers are pushing for a national health scheme in the U.S. that would resemble Canada's in limiting the profits made by the health-care industry. It would be funded out of payroll taxes and applied progressively, without the current cap that shields some of the earnings of the rich. And a lot of what we now spend on private health insurance we'd spend instead, more efficiently and equitably, to support a national health scheme.

Flynn graduated from nursing school in 1941, and she is worried about the way the entire medical-delivery system in the U.S. has changed lately. The problem, she said, is not demographics but greed. "The whole invasion of for-profit hospitals in our area is only twelve years old," she told

me. "Doctors who own laboratories, hospitals that talk about 'customers.' Texas has a thousand nursing homes." (For-profit nursing-home chains kicked out of other states start up in Texas, she said, because there's less initial regulation.) Even Medicare earns a profit for the private insurance companies that administer it.

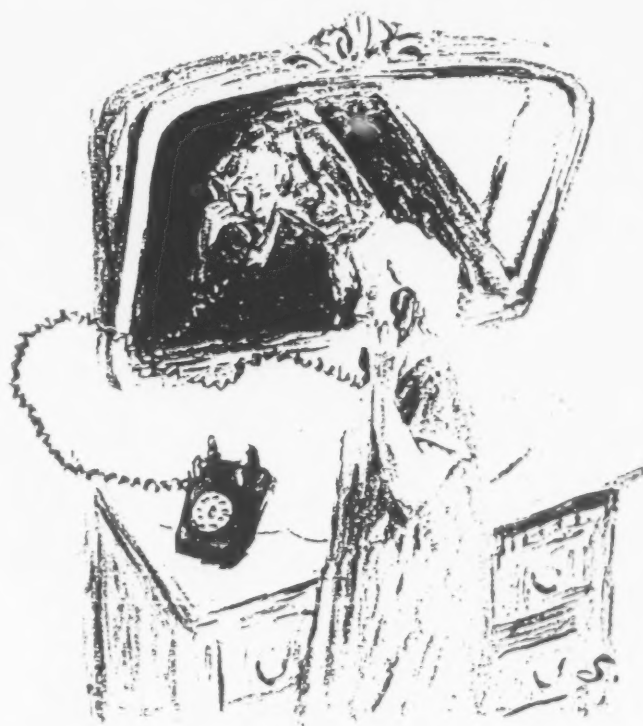
With the rest of the world suddenly discovering the profit motive, is this the time to impugn it in the U.S.? I like the Gray Panthers' forthright radicalism, but what chances does it

it. She suggested Nicole look for something of the sort. It struck me that support groups are what many Americans in crisis have instead of family or community. Nicole, on the other hand, learned to get by as an only child, and wasn't having any of it. ("What do I want to listen to other people's troubles for?" she said later. "I have enough of my own.")

When Flynn said, "We need to recognize the people who are caregivers," we both knew she was talking about values that went beyond the

political. While Nicole's husband was at his office the other day, doing the world's work, she was sitting on the edge of the bathtub at home, waiting for her mother to pee. When it turned out she couldn't, Nicole rushed her to the hospital again. She called me later to report. "They couldn't get her into bed, so they laid her on a sheet, lifted it up, and rolled her onto the bed. You should have seen her bounce, like on a trampoline, with all her tubes and her Chanel bow askew and her little nightie. The nurse leaned over and said, 'Hello, Mrs. D.,' and you know what my mother said? She hadn't spoken a word all day,

you realize, and then, with perfect timing, she comes out with, 'What do you mean by "hello"?' The nurses cracked up, they were going along the floor telling the other nurses." I was glad to hear Nicole so upbeat, although I understood part of it was relief at knowing she'd be getting a night's sleep while the hospital looked after her mother for a change. But in my mind's eye I saw the Chanel bow. I saw Nicole leaning over and pinning it in her mother's hair, just so. And that was also part of the world's work. Somebody ought to tell her.



have? "We're sort of a remnant," Flynn conceded. "I work with people who were sixties activists, and who are in their forties now." Recently, however, the Panthers and other progressive groups in Austin held a training workshop for high school and college students who want to become the next generation of activists.

I asked her what help the Panthers could offer someone like Nicole or her mother, and she mentioned a course organized by a member called "As Parents Grow Older," and told me about a support group that grew out of

case managers is filling a gap in the long-term care continuum by offering services unavailable through Medicare, Medicaid or other public programs. They oversee assessment, care planning and service support while negotiating our increasingly complex system for elders and their families.

Accompanying the field's rapid growth, though, are emerging concerns about numerous ethical, consumer and conflict-of-interest issues in private case management. There are few, if any, federal or state regulations governing those entering this potentially lucrative field. For example, while some individuals may have to meet licensure and ethical code requirements within their professions—such as nursing, medicine or psychotherapy—others are essentially unregulated. Social workers, for instance, do not have to be licensed in some states.

Rapid Growth

Many groups and individuals, of course, already perform care management functions within their normal course of work, for example, home healthcare agencies or hospital discharge planners. A major reason for the emergence of private case management as a distinct field has been the nation's booming elderly population, including many who either do not qualify for publicly funded programs or who require services unavailable from public agencies.

Another impetus for the growth of care management is concern about healthcare costs and the growing number and types of services. These trends have converged with a new entrepreneurial drive among human services professionals, chiefly nurses and social workers. Others eyeing this quickly expanding career area include physicians, psychologists and attorneys.

This new field even has its own professional organization, the National Association of Private Geriatric Care Managers (NAPGCM), whose membership of nearly 300 has more than doubled annually since it was founded five years ago.

Concerns discussed at the group's recent national conference in San Diego included barriers to access to case management and related long-term care services, quality of case management, case manager allegiance (for instance, to the older person versus a family member or a payment source) and a variety of other ethical and

practical issues their families to resolve issues of terminating life-sustaining technology?

Who will make decisions for demented individuals, and should the person's presumed safety or self-determination and autonomy be the guiding concern?

What protections need to be given elders when courts appoint private case managers as guardians or extend them other powers over the person's life, money and resources? Should case managers be

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independent or be permitted to work for nursing homes or home care agencies that may have a stake in decisions? Should they work for government agencies, where cost containment may be the main goal?

Should care managers serve as board members of organizations from which they may receive or to which they may send

Chronic Care Workers

Pay, Conditions Compromise Quality

There are an estimated 1.5 million nursing and home health aides providing most of the long hours of chronic care to elders in the United States after the doctor, nurse or case manager has left. We will need another half-million by 2000.

Aides are responsible for virtually all personal care, such as bathing, feeding, toileting and dressing. Most of them are middle-aged women, including a disproportionate number of minorities (38% black or Hispanic) and foreign born. According to a recent report by the Older Woman's League (OWL) and the American Federation of State, County and Municipal Employees, "They receive little or no training, yet care for an increasingly sick and disabled population."

The report found that a shortage of aides "can be directly linked to the woefully inadequate pay and fringe benefits... and to adverse working conditions, including hours, understaffing, lack of training and absence of promotional opportunity."

One study of home health aides in New York City, for example, found that three in four provided their family's primary support, but the yearly income of 90% of the sample amounted to less than \$11,000 per year (median family income for all was about \$8,000).

The primary reason for the shortage, says the report, "Chronic Care Workers: Crisis Among Paid Caregivers of the Elderly," is that the nation's 7,000 hospitals, 25,600 nursing and related care homes and 12,000 home health agencies that employ most aides "are under growing pressure to contain costs, while at the same time to increase staffing levels of registered nurses, for which there is an even greater shortage."

The demand for aides will be particularly high among nursing homes. According to the report, the proportion of aides working in such facilities will jump from 44% in 1986 to 56% in 2000, while hospitals will drop from employing 31% of all aides to just 19%.

The document continues, "The burdens of cost containment cannot be borne largely by an exploited female workforce." It questions the artificial distinction that pays more for so-called skilled labor: "Aides are oppressed by the acute medical model that still dominates long-term care services, as the 'skilled' and 'custodial' categories of care spawned by Medicare lock them into underclass status."

"Chronic Care Workers" explains further that among nursing home workers, aides sustain the highest turnover rates, from 70% to 100%. It adds, "On average the turnover rate is 60% for 'para-professionals' who work in home care; 80% to 90% leave within two years."

One improvement in the offing is the Health Care Financing Administration's (HCFA) mandate of substantial new training requirements for aides in nursing homes (see "Nursing Home Reform," in *The Aging Connection*, August/September 1989). The implementation of the OBRA 1987 rules, however, was delayed until October 1990.

The 31-page report is available from OWL, 730 11th St., NW, Suite 300, Washington, DC 20001, for \$7 (\$5 for OWL members). It comes with an attractive supplement, "Basic Facts About Chronic Care Workers," and a copy of the 10-point "Chronic Care Workers Bill of Rights."

OPINION

Care givers sandwiched between young and old

By NANCIE FADELEY

MOTHER'S DAY IS TRADITIONALLY a time to thank women for the care they have given the young. However, this year in its annual Mother's Day report, the Older Women's League reminds Americans that mothers' care-giving days do not end when the children are grown, and that whether they choose to or not most women spend more time caring for adults than for children.

Today, a woman can expect to spend 17 years caring for children and 18 years helping an aging parent. Other years will be devoted to disabled husbands, relatives and in-laws.

This year's report titled "Falling America's Caregivers: A Status Report on Women Who Care" is particularly timely because policy makers are beginning to respond to the child care needs of parents. The Older Women's League is trying to get those same policy makers to also address the concerns of the many women who provide the unpaid care that keeps their loved ones out of nursing homes where most of the costs are billed to the taxpayer.

Many of these women are elderly themselves — 35 percent are over 65; 10 percent are over 75 — dealing with the chronic effects of aging that make the burden of giving care especially difficult. Almost 2 million women are members of the "sandwich" generation, caring for children and parents at the same time.

Although there are similarities between caring for the young and caring for the old, there also are differences. Care-giving tasks lighten as children grow in stature and

independence; care-giving tasks become more burdensome as the frail elderly become weaker and more dependent. Mothers can look forward to times of respite and return to full-time employment when their children go off to day care or to school; the future for care givers of the elderly holds no such promise.

Contrary to the common belief that most of America's elderly are in nursing homes, only 5 percent are institutionalized. About 7 million Americans are unpaid care givers of the elderly — care givers who are coping for free with problems government otherwise would be unable to ignore.

In an effort to get policy makers to recognize society's responsibilities to these care givers, OWL is continuing its annual tradition of sending Mother's Day cards to legislators. As in the past, these cards remind lawmakers that mothers need more than candy and flowers. This year's card, which is illustrated with a simple line drawing of a frail hand touching two stronger hands, lists some suggestions for congressional action and the reminder that "Women who care need care too."

In recent years, in part due to the efforts of OWL and in part due to the growing recognition that the aging of America's population brings with it increasing demands for care, lawmakers have addressed some care-giver concerns.

Even though it refused to include long-term care in the Catastrophic Coverage Act adopted last year, Congress did lessen the risk of spousal impoverishment, one of the cruelest prices demanded of care givers who can no longer keep their spouses at home.

Spousal impoverishment often comes with a series of

surprises — surprise at learning that Medicare and most insurance policies do not pay for long-term care and surprise at learning that in order to get help from Medicaid a family must "spend down," i.e., deplete their financial resources, to become eligible for welfare. Provisions of the new law will allow the spouse who is not institutionalized to retain a limited amount of family assets (at least \$12,000) and income (122 percent of the poverty level) at the same time Medicaid pays nursing home costs.

However, there still is little help for those who care for their spouses at home. In a number of ways, Oregon has been a leader in recognizing these needs. The elder day care center, a part of Gov. Bob Straub's Project Independence in the mid-1970s, was a pilot for today's new centers which, even though their costs may be high, usually have waiting lists soon after opening.

Another aid to family care givers comes from Oregon's leadership in getting the federal waiver of restrictions on Medicaid funds that otherwise can only be spent on institutionalized care. Thus, home health aides paid with Medicaid money are providing respite and help to family care givers. On the other hand, this movement away from institutionalization may not be doing all family care givers a favor because many frail elderly who otherwise might be in nursing homes are placing uncounted costs on unpaid care givers.

This Mother's Day, OWL also is asking lawmakers to recognize the economic costs of care-giving to the employee whose present and future income may be affected because care responsibilities force her into less demanding jobs or early retirement.

Some states — and proposed congressional legislation — provide job protection for workers who take time off to care for family members. In 1987, Oregon adopted a family leave act which requires employers to let employees take unpaid leave when they become new parents, but not when they must care for adults.

Last fall, OWL and the American Federation of State, County and Municipal Employees, AFL-CIO, issued a report titled "Chronic Care Workers: Crisis Among Paid Caregivers of the Elderly," a study which is perhaps even more sobering than OWL's Mother's Day report. These nursing aides and home health aides are underpaid — typically close to or at the minimum wage — and in short supply. They lack training and their job turnover is high. Their work is stressful, unappreciated and exhausting. It offers few opportunities for advancement.

It is appropriate to note the problems of these chronic care workers on Mother's Day because most of them are women and most of the elderly they care for are women, women who have no one to give them the unpaid care they gave their spouses.

During debates on public health care policy, these workers are seldom mentioned. Yet Americans receive most of their long-term care, not from doctors or nurses, but from chronic care workers who are paid below poverty wages and family care givers who are paid nothing at all.

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APPENDIX F

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